

FEELING UNDERSTOOD: THE LIVED EXPERIENCE OF
CULTURALLY COMPETENT NURSING CARE
AS PERCEIVED BY PATIENTS OF CHINESE ETHNICITY

by

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ABSTRACT

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The purpose of this qualitative study was to gain an understanding of the patients' perceptions of the lived experience as recipients of culturally competent nursing care related to their cultural values, customs, and health beliefs. A review of the literature revealed that culturally competent nursing care is the basis of providing holistic, individualized care. However, as culturally competent care has gained momentum in recent years, healthcare disparities in the United States remain, particularly among underserved minority and vulnerable groups of multicultural backgrounds. Literature suggests a link between culturally competent nursing care and improved health outcomes. This connection has been the motivation for nursing professionals to embrace culturally competent care and work to close the gap of incongruence of quality healthcare for all individuals.

Van Manen's phenomenological research method was used to reveal the essence of the lived experience of culturally competent nursing care as perceived by participants of Chinese ethnicity. The phenomenon was the experience of being in a hospital receiving nursing care as a patient from diverse cultural background. The context of the phenomenon was healthcare organizations that purport to provide exemplary culturally competent care. Following interviews of nine participants, transcripts were analyzed. Data analysis revealed four themes: (a) nurse's presence; (b) feeling understood; (c) nice nurse, happy nurse, happy patient related to nurses' caring behaviors and the impact on one's perception of their health; and (d) gratitude. The concept of connectedness was an overarching theme within each of the four identified themes, serving as the thread among all interviews and themes. Watson's Human Caring Science Theory of Nursing provided a framework for the themes and overarching theme. In this qualitative study, participant interviews contributed to building the body of knowledge about culturally competent care that shed light on Chinese participants' meaningful nursing care experiences.

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DEDICATION

To my mother, Nanette Little Grundy, a most intelligent woman who did not graduate high school and yet taught me the value of education and lifelong learning. Her caring and kindness toward everyone she met provided the foundation for my nursing career.

To my daughter, Amanda Christine Walker, who is a precious gift and eternal joy.

To my patients, who over the years have entrusted their care to me and taught me the meaning of compassion.

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This acknowledgement is for all those who supported and encouraged me in my journey of receiving a doctoral degree in nursing. *“No matter what great things you accomplish, someone helps you.” Wilma Rudolph*

Thank you to my family and friends for believing in me, forgiving my absences, and loving me always. I could not have accomplished this without you.

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“Within the four seas, all men are brothers.”

(Translation: All human beings in the world are one family.)

(Herzberg & Herzberg, Chinese Proverbs with
Observations on Culture and Language, 2012, p. 10)

Chapter I

INTRODUCTION

The Chinese proverb affirms that all human beings are essentially one family of “brothers,” regardless of one’s culture, “within the four seas” (Herzberg & Herzberg, 2012). The proverb could be interpreted to suggest that since all human beings are of “one family,” then all people have basic fundamental rights. A position statement by The American Nurses Association (ANA, 2010) stated that healthcare is a basic human right and upholds its position “that all individuals living in the U.S., including documented and undocumented immigrants, should have access to healthcare” (p. 1). Yet within the United States alone, healthcare disparities pose a significant barrier to provision of equitable healthcare for all people. A variety of factors that contribute to healthcare disparities range from economic status, race, ethnicity, age, language, ability to communicate, immigration status, sexual orientation, disability, and health literacy (Healthy People 2020, 2010; Kimbrough, 2007). The Institute of Medicine’s (IOM) report, *Crossing the Quality Chasm*, identified that for healthcare systems to achieve high quality, integration of cultural competence which detect disparities “would lay the foundation for targeted quality improvement activities” (Betancourt, 2006). Elimination of the inequalities in healthcare necessitates a holistic approach that incorporates care

from the cultural perspective of the patient. According to the Office of Minority Health (OMH, 2013), a division of the U.S. Department of Health & Human Services (HHS), “cultural competency is one the main ingredients in closing the disparities gap in healthcare” (Cultural Competency section, para. 2).

Nursing professionals have been explicitly called upon to embrace culturally competent care and work to close the gap of incongruence of quality healthcare for all people within communities of the United States. The Joint Commission (2011) and the American Association of Colleges of Nursing (AACN, 2008) are two foremost organizations that advocate for culturally competent care to be assimilated into nursing education and practice with the goal of providing curricula and standards of practice that address issues related to inequalities of healthcare. The IOM’s report, *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine [IOM], 2011) was based on the IOM’s Quality Chasm series of reports and challenges nursing to redesign our healthcare system to ensure safe, quality care for all persons; for all “brothers” living within our borders (Herzberg & Herzberg, 2012).

Culturally Competent Care

According to the ANA (2010), as cited in the introduction section, all people have the basic human right to healthcare. However, within the U.S. healthcare system, disparities do exist in both the access to care as well as the quality of care for individuals of minority backgrounds and those within other vulnerable groups (Healthy People 2020, 2010; IOM, 2002; Kimbrough, 2007; OMH, 2013). A major influence that has been identified to alleviate the widening gap of healthcare disparities for minority and

vulnerable groups is the provision of culturally competent care by healthcare professionals (Betancourt, 2006; IOM, 2002; OMH, 2013). The problem is, although there is a plethora of research on the topic of culturally competent care within nursing and the other health professions, there is a lack of qualitative research that can provide an understanding of the meaning of culturally competent nursing care from the perspective of those who have been recipients of such care.

The question remains as to the real value of culturally competent care. The research to date provides steadily growing evidence that culturally competent care makes a positive difference in the level of patient satisfaction with their healthcare experience (Betancourt, Green, & Carrillo, 2002). To a lesser extent, there is some beginning evidence that culturally competent care can also improve patient health outcomes, yet this area requires further development (Bender, Clark, & Gahagan, 2014; Callister, 2005; Jones, Cason, & Bond, 2004). Use of the phenomenological method of research can be an effective means to gain a greater understanding of the lived experience of culturally competent nursing care as perceived by patients who have been recipients of care. To date, there were no nursing studies located that have examined the experience of culturally competent nursing care from the perspective of the patient. Previous studies have focused primarily on the nurse's understanding of the patient's culture versus understanding the patient's perception of culturally competent nursing care. In the phenomenology of perception, Merleau-Ponty (1945/2012) believed that "the subject of perception will remain unknown. ... so let us return, then, ... and examine it closely enough such that it teaches us the living relation of the one who perceives with both his body and his world" (p. 216). By examining cultural competence from the patient's

perception of the experience, the true value of culturally competent nursing care can be revealed.

Background of Nursing Studies on Cultural Competence

The evolution of nursing professionals developing an understanding of patients' culturally based health beliefs and practices has spanned a time period of more than 50 years and has provided the foundation for culturally competent care. Review of the literature revealed a sundry of mostly descriptive and narrative qualitative studies, and to a lesser extent quantitative studies, that have focused on select culturally competent nursing interventions for various racial and ethnic groups. The studies have concentrated on nurses' understanding of various cultural preferences to develop innovative nursing approaches that provide individualized, holistic, culturally competent, and patient-centered care. The problem is there are many studies on cultural competence but the qualitative research has not addressed the question of what is the meaning of this type of nursing care from the patient's perspective.

Overall, these nursing studies have led to the development of well-established theoretical frameworks and models of culturally competent care in nursing as well as evaluative instruments to measure cultural competence for practice (Campinha-Bacote, 2002; Jeffreys, 2010, 2013; Leininger, 1967, 1997; Purnell, 2005). On a system-wide level, national standards have provided a blueprint for healthcare organizations to establish culturally competent healthcare services (Institute of Medicine, 2011; Office of Minority Health, 2001; The Joint Commission, 2011). Yet with the plethora of nursing studies on culturally competent care, there remains a gap in understanding the impact of the experience of culturally competent nursing care from the perspective of the patient.

In response to the evolution of nursing research in culturally competent care, professional organizations, accrediting bodies, and governmental agencies today have developed mandates for culturally competent care education in all nursing academic programs and nursing practice models (American Association of Colleges of Nursing, 2008; Institute of Medicine, 2011; The Joint Commission, 2011). One challenge to nursing education based on the established theories and models which make-up the concept of culturally competent care is the variations of definitions that exist. Several terms or labels have been used to describe culturally-based healthcare. Some of these include culturally competent care, culturally congruent care, culturally relevant care, culturally sensitive care, and culturally specific care. Although these terms are similar, precise definitions for culturally competent nursing care fluctuate among nurse theorists (Long, 2012). Culturally congruent care defined by Leininger (1995) was described as “cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with individual's, group's, or institution's cultural values, beliefs, and lifeways”. Campinha-Bacote (2002) described cultural competence as “the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client.” Synthesizing the literature that defines culturally competent care, the definition used for this study was that it is a patient-centered care approach which is based on a commitment to provide quality nursing care for all persons that is individualized, holistic, and results in health equity for those minority and vulnerable patient populations subject to healthcare disparities.

Diversity, Healthcare Disparities and Culturally Competent Care

An increasingly diverse population in the United States has prompted wide-spread initiatives for the nation's healthcare system and health providers to respond to patients' cultural perspectives, values, and beliefs about health and illness (Betancourt et al., 2002). Statistics according to the 2012 National Population Projections (United States Census Bureau, 2011) predict that the U.S. will become a more diverse nation and is classified to become a "majority-minority nation for the first time in 2043." Long-standing healthcare disparities continue to magnify and pose a significant threat to the nation's health with substantial health consequences for minority groups (Betancourt et al., 2002; Institute of Medicine, 2002). According to a blog posted on the online site for healthcare consumers, FamiliesUSA (Murillo, 2013) "racial and ethnic minorities bear a disproportionate burden of chronic illnesses, are more likely to be uninsured, face unequal access to quality healthcare services, and suffer worse healthcare outcomes than the general population." The AACN (2008) cited that the rationale for use of cultural competency in nursing for the elimination of health disparities is to "support the development of patient-centered care which identifies, respects, and addresses differences in patients' values, preferences and expressed needs" (p. 1).

Disparity also exists between healthcare providers and the general patient population. The Health Resources and Services Administration (HRSA, 2013) of the U.S. Department of Health and Human Services found that although there has been increasing diversity of the patient population, there has not been a corresponding increase in diversity of the workforce in health professions. Culturally competent care is very relevant for minorities and other vulnerable groups since they have a unique culture

unlike patients who represent the majority. However, the majority of caregivers are from the majority and often do not relate to the culture of the minority. A workforce analysis by HRSA (2013) found that nursing is predominantly white, although, the trend has shifted from 80% in 2000 to 75% in 2010. According to HRSA (2013), diversity within the nursing workforce is important because it can improve the quality of care and health outcomes for minority populations. The incongruence between workforce and patient population is important to recognize because nursing has been called upon to lead the change to achieve safe, quality, and equitable care for individuals in all segments of our society (IOM, 2011). On a national level in particular, there has been a concentrated emphasis to integrate culturally competent care into the education and practice of nursing (AACN, 2008; The Joint Commission, 2011).

Vulnerable populations are those groups that are “not well integrated into the healthcare system because of ethnic, cultural, economic, geographic, or health characteristics” (Urban Institute, 2010). Members of these groups become isolated from receiving necessary medical care, which results in disparities of healthcare (Urban Institute, 2010). Although these individuals remain isolated from healthcare for various reasons, the major contributing factors are the language and cultural barriers between healthcare providers and patients (Urban Institute, 2010).

Identification of minority and vulnerable groups has not been exclusively defined but there are commonly recognized populations that fall within the categories of “minority and vulnerable groups”. The definition of “minority group” based upon data from the United States Census, includes African-Americans, Hispanics, Asian/Pacific Islanders, and Native Americans/Alaska Natives (Betancourt et al., 2002; Institute of

Medicine, 2002; Office of Minority Health, 2013). Inclusion of vulnerable groups refers to not only racial and ethnic minorities, but also gender, sexual identity and orientation, disability status or special healthcare need, geographic location (rural and urban), poor socioeconomic status and income, education, age, and others (Agency for Healthcare Research and Quality [AHRQ], 2003; Healthy People 2020, 2010; Kimbrough, 2007; Urban Institute, 2010). Specific groups may include but are not limited to immigrants (documented and undocumented), refugees, low-literacy, non-English speaking, lesbian/gay/bisexual/transgender/queer (LGBTQ), disabled (physical/sensory), visually impaired, incarcerated, and the elderly. To reduce healthcare disparities it is important to examine the experience of culturally competent nursing care for the various segments of our population.

Justification for the Study

In a world where immigration has shifted the demographics creating greater ethnic diversity, nurses are faced with the challenge to “meet the special needs of a culturally diverse society” (Jones et al., 2004). Disparities in the healthcare workforce, primarily a result of the composition of the workforce compared to the overall population and a shortage of healthcare providers, underscores the significance of cultural competence (Office of Minority Health, 2013, HHS Disparities Action Plan section, p. 3). Healthcare providers whose racial, ethnic, and sociocultural backgrounds differ from their patients can create challenges to communication and provision of effective, quality care (Institute of Medicine, 2004; Office of Minority Health, 2013, HHS Disparities Action Plan section, p. 3). “The provider and the patient each bring their individual

learned patterns of language and culture to the healthcare experience that must be transcended to achieve equal access and quality healthcare” (Office of Minority Health, 2013, Cultural Competency section, para. 2). An additional factor to consider when regarding the diversity gap of the healthcare workforce is that, today, the nursing workforce consists of nurses from four different generations that bring diverse experiences to the workplace (Sherman, 2006). This generational diversity can present challenges, particularly in education and leadership, as well as add “richness and strength” as they provide care in a multicultural nation (Sherman, 2006). Commitment of the healthcare workforce to respond to the disparities in care and address the health needs of diverse communities relies on cultural competence so all people can achieve their potential of optimal health (Betancourt, 2006; Institute of Medicine, 2004; Office of Minority Health, 2013, HHS Disparities Action Plan section, p. 3). The key for nursing professionals in an age-diverse workforce providing care in culturally-diverse communities is to value each person with respect and dignity and strive to reach their full potential as culturally competent caregivers (Betancourt, 2006; Institute of Medicine, 2004; Office of Minority Health, 2013, HHS Disparities Action Plan section, p. 3; Sherman, 2006). Understanding a person’s perspective of their beliefs of health, illness, and health practices can facilitate nurses’ capabilities to validate individual cultural preferences and to provide culturally competent nursing care.

The nursing theorist, Leininger (1967), long ago understood the essential nature of cultural competence in providing nursing care. Leininger (1991) believed that the use of transcultural care knowledge is essential for accurate, reliable healthcare. Culturally competent care has become an important aspect of healthcare as society has become

increasingly diverse (Coffman, 2004). Leininger's classic work of the 1950s is ever relevant today, as the world has undergone unprecedented change related to such factors as globalization and technology (Horn, 2006). "Clearly, holistic healthcare is in great demand today, which necessitates in-depth understanding of cultural and care phenomena to provide culturally congruent and effective nursing care" (Horn, 2006, p. vi). Nursing care that integrates the culture of the person to provide relevance for the patient and that results in positive health behaviors would have a powerful effect on the, "wellness, health, and wellbeing of people as they are helped to attain, regain, or maintain health within their familiar contexts" (Leininger & McFarland, 2006, p. 10). Hence, the goal of this study was to contribute to the body of nursing knowledge that can provide nursing professionals with the perspective of culturally competent nursing care experiences as seen through the lens of the patient. The findings of this research may be used to expand nurses' knowledge, encourage nurses to provide effective culturally competent care, and enable the nursing profession to lead in the evolution of patient-centered healthcare.

Purpose of the Study

The purpose of this study was to gain insight into the meaning of the lived experience of culturally competent nursing care provided to patients of Chinese culture and ethnicity. Gaining an understanding of patients' perception into the meaning of culturally competent nursing care within the context of their culture may contribute valuable information to the body of nursing knowledge.

The Phenomenon

Phenomenology is the study of an individual's life world in order to gain a deeper understanding of the meaning of the experience (van Manen, 1990). The phenomenon that was investigated for this study was the experience of being in a hospital receiving nursing care as a patient from diverse cultural background. The context of the study was the patient's culture as they were recipients of nursing care in a healthcare organization nationally recognized for exemplary provision of culturally competent care. This phenomenon was examined in those persons of Chinese ethnicity. It is essential for nurses to understand the link between what is believed to be culturally competent nursing care and the meaning that is ascribed by the patient having had the lived experience of such nursing care.

It is appropriate to gain the patient's meaning of culturally competent nursing care through phenomenological study. According to Munhall (2012), the findings from the phenomenological method can be used for "policy development, change in practice, increasing our capacity for care and compassion, emancipation from oppression, and raising our consciousness of what was not known or otherwise erroneous" (p. 121). The perception of the lived experience from the individual's unique worldview is what matters most; therefore what is important "is not what is happening, but what is perceived as happening" (Munhall, 2012, p. 128). The goal of this study was to identify shared themes and patterns of patients' experiences of culturally competent nursing care received in a healthcare environment recognized for providing exceptional culturally competent care. Awareness of the emergent themes may add significance to the body of nursing knowledge in understanding patients' perceptions of culturally competent care.

Research Question

What is the lived experience, from the perspective of the patient of Chinese cultural background, who has been a recipient of culturally competent nursing care?

Assumptions, Biases and Experiences

As nurses and other health professionals provide care in our multi-cultural society, there remains the question of the benefits of culturally competent nursing care, particularly for underserved minority and vulnerable groups. My assumption was that the overall result of culturally competent nursing care can result in a patient-centered approach that is focused on not only gratifying experiences for the patient but also on maximizing patients' health outcomes. However, before determination of the impact of culturally competent nursing care on health outcomes can be made, it is important to examine the question of what is the patient's perception of the meaning of the culturally competent nursing care experience.

The primary site for the study, as discussed in Chapter IV, was a hospital that was nominated by the American Hospital Association (AHA) for the Equity of Care Award. The nomination was in recognition for implementation of initiatives that specifically focused on the cultural healthcare needs of its patients as represented by the various cultures within its diverse community. The assumption for this study was that hospital with such a prestigious award would provide culturally competent nursing care and that from the viewpoint of the participant, they would experience exemplary culturally competent care.

My primary bias of the role of the nurse as caregiver is that, more than other healthcare providers, the nurse can best serve as patient advocate. In providing nursing care for over 30 years in the acute care setting, I have come to learn that the patient is the one that knows their body and mind best, and it is a wise practitioner that listens to the patient's perspective of their health views and practices. It is my belief that nurses have an ethical responsibility to provide leadership in bridging the gap between the inequities of healthcare with holistic, culturally competent nursing care for underserved minority and vulnerable groups.

Significance of the Study

In today's healthcare system, there have been collaborative efforts nationally to reduce the disparities in healthcare in the United States. Health disparities was defined by the National Conference of State Legislatures (NCSL, 2012) as a difference in the access and quality of healthcare that exist for racial and ethnic groups which has resulted in poorer health outcomes for these populations. One approach to achieve better healthcare for underserved minority groups has been a concentrated emphasis to provide culturally competent care to address the individual needs of patients from diverse backgrounds. The *Healthy People 2020* government initiative has included a focus on the elimination of disparities with improved health for all groups and has expanded the groups to include not only race and ethnicity, but also sex, sexual identity, age, disability, socioeconomic status, and geographic location (Healthy People 2020, 2010). To promote this goal, The Joint Commission accreditation agency of hospitals set standards, which "support effective communication, cultural competence, and patient- and family-centered

care” (The Joint Commission, 2011). The U.S. Department of Health and Human Services Office of Minority Health established the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare (OMH, 2001, 2013). The National CLAS Standards were developed to create a framework to inform, guide, and facilitate culturally and linguistically health services (Office of Minority Health, 2013, Cultural Competency section).

Despite these advances to assimilate culturally competent and high-quality healthcare for racial and ethnic minorities as well as for other vulnerable groups, there still lacks the understanding of culturally competent nursing care from the perspective of the patient. The significance of this study was to gain the perspective of the patient’s experiences as the recipient of culturally competent nursing care. The goal of culturally competent nursing care is to improve health outcomes and decrease healthcare disparities for underserved minority and vulnerable populations. Nurses fulfill an essential role to render culturally competent nursing care to the people they serve.

Relevance to Nursing

Nursing is pivotal to reduce healthcare disparities. Lack of caring contributes to health disparities, and since caring is central to nursing, it makes the nursing profession best suited to address issues of disparities (Smith, 2007). Collaborative relationships between the patient and nurse in which care is culture-specific can promote patient-centered care that includes culturally competent nursing care as an integral part of their overall care. This caring, relationship-based nursing approach can lessen health disparities by integrating the “worldview” of the patient into an individualized and

holistic plan of care. As patients become active partners in their care, there is the potential for more effective prevention and restoration of health and management of chronic illness, for all groups and populations.

Nursing, as a caring profession, respects the rights of all persons to have access to quality healthcare that is congruent with their cultural beliefs, values, and customs. The leadership role of the nursing profession related to healthcare disparities is to lead the effort to provide and evaluate the effectiveness of culturally competent nursing care on inequalities of healthcare for minority and vulnerable populations. To lessen healthcare disparities it is essential for nursing to approach the care for others through the paradigm of understanding culturally competent nursing care from the patient's perspective or "worldview".

Summary

The aim of the study was to gain an understanding of patients' perceptions of culturally competent nursing care and the relevance of that care for patients of Chinese ethnicity. The phenomenon of interest for the study was the hospitalized patients' experience, of those patients of Chinese culture, as a recipient of nursing care. The context of the study was the patients' culture as they were recipients of nursing care in a healthcare organization nationally recognized for exemplary provision of culturally competent care. Healthcare disparities in the U.S. healthcare system, which include unequal access to care as well as inadequate quality of care, and the lack of studies that provide insight into the patient's perception of culturally competent nursing care, provided the justifications for the study. The significance of the study to nursing was to

gain an understanding of patients' perceptions of culturally competent nursing care that will expand nurses' knowledge of the meaning of culturally competent nursing care and to provide leadership in bridging the gap of healthcare disparities.

Chapter II presents the historical evolution of culturally competent care in nursing and the context for the phenomenon.

“Culture and care are embedded in each other and need to be understood within a cultural context.”

(Leininger, Theory of Culture Care
Diversity and Universality, 2006, p. 4)

Chapter II

EVOLUTION OF THE STUDY

This chapter includes a review of the literature from a historical context that focuses on the evolution of culturally competent care in the United States and the concurrent nursing theory development of culturally competent nursing care. The literature review includes five primary topic areas: (1) the impact of diversity in the U.S. contributing to disparities in quality healthcare for minority and vulnerable populations and its linkage to an evolving culturally competent healthcare system, (2) development of nursing theories in culturally competent care, (3) theoretical influences of culturally competent nursing care on the care of the patient, (4) the evolution of culturally competent nursing care for diverse populations, and (5) traditional Chinese philosophies that provide the foundation for Chinese patients' health beliefs. A personal reflection of my interest and experiences in culturally competent nursing care related to this study are included in the chapter.

Historical Context

Disparities and Discrimination: The United States as a “Melting Pot” and the Evolution of Culturally Competent Healthcare

America began as a multiethnic and multicultural society (Perez & Hirschman, 2009). Through the historical waves of immigration in this country, the ethnic and racial landscape has become more complex (Perez & Hirschman, 2009). According to Perez and Hirschman (2009) most Americans, except for those that have recently immigrated to the U.S., are likely to be descended from various geographic, ethnic, and racial heritages. The Pew Research Center’s (2008) report for racial/ethnic composition in the U.S., predicts that by 2050 Whites will make-up less than 50% of the population. Minorities are expected to increase to 29% for Hispanics, 13% for Blacks, and 9% for Asians.

This expanding diversity was the dynamic for change in the delivery of healthcare in the United States. Demand grew for healthcare providers to shift the focus from services based on the Western model of care and treatment to one that was responsive to ethnic minority groups, low-income populations, and underserved groups (Chin, 2000). The movement toward culturally competent care began with an emphasis on healthcare services that centered on *cultural sensitivity* (Chin, 2000). In the 1960s, cultural sensitivity took on the meaning of provision of language services for non-English speaking immigrants, as well as addressing cultural barriers affecting, “people of color” who are unable to access healthcare services (Chin, 2000). By the 1980s, the movement evolved to a call for culturally competent care not only by providers but also at the healthcare organizational level (Chin, 2000). The evolution from the early days’ focus on the availability of bilingual/bicultural providers to speak with patients in their native

language shifted to developing knowledge of the patient population served (Chin, 2000). During the 1990s, cultural competence moved beyond understanding of a patient's culture toward the provision of culturally appropriate care by healthcare providers and systems (Chin, 2000). Notably, cultural competence came to be a civil rights issue in the 1990s. The passage of the Disadvantaged Minority Health Act in 1990 served to expand the Civil Rights Act of 1964 by declaring inadequate interpretation as discriminatory (Chin, 2000).

Today there is much to be done to close the gaps in equitable care for people of all cultures. Potential areas for development identified by Chin (2000) included translation of cultural competence goals into quality indicators, identification of providers by ethnicity to allow consumer choice, instituting measures of cultural competence for credentialing, reimbursement for interpreter services, and assessment of healthcare utilization patterns by different racial/ethnic groups. In looking back over the evolution of culturally competent care, although many strides have been made for more than fifty years, it is evident that healthcare in the United States still has not fully transformed into one that is equally provided for all population groups.

Diversity, Healthcare Disparities and Cultural Competence

The nation's growing diversity has meant that many people of minority and vulnerable groups cannot access healthcare and/or they are not provided with quality healthcare (The Sullivan Commission, 2004). A key approach to reverse this trend has been the call for healthcare providers to develop cultural competence in providing care to diverse populations. The integration of cultural competence training to close the gap of healthcare disparities in the U.S. was the primary focus of the IOM's report (Institute of

Medicine [IOM], 2002), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. This report highlighted how ethnic minorities tend to receive a lower quality of healthcare even when the factors of health insurance and income are controlled. The factors contributing to healthcare disparities are complex and multifactorial (Smedley, Stith, & Nelson, 2003). One primary barrier to equitable healthcare was “cultural familiarity” (Smedley et al., 2003). The identification of this barrier led to one of the key recommendations of the report, #6-1, which was to “integrate cross-cultural education into the training of all current and future healthcare professionals” (Smedley et al., 2003, p. 20). The goal of cross-cultural education was to contribute to lessened healthcare disparities by “increasing provider understanding of cultural and behavioral aspects of healthcare and improving communication strategies” (Smedley et al., 2003, p. 20).

The Sullivan Commission report (2004), *Missing Persons: Minorities in the Health Professions* described the work of the Commission’s field hearings that collected information and identified solutions aimed to diversify the health professions. The work was a collaboration of and supported by the W.K. Kellogg Foundation and Duke University School of Medicine. The report cited that African Americans, Hispanic Americans, and American Indians collectively constitute 25% of the population, yet these three groups accounted for less than 9% of nurses, 6% of physicians, and 5% of dentists (The Sullivan Commission, 2004). The shortage of minority health professionals is compounding the problem of persistent healthcare disparities for racial and ethnic minority groups and importantly, research has shown that minority health professionals are more likely to serve in minority and medically underserved communities (The

Sullivan Commission, 2004). The data collected by the Commission revealed that cultural differences, lack of access to healthcare, and increased poverty and unemployment contribute to the disparities in healthcare and poor health outcomes (The Sullivan Commission, 2004). The Commission put forth strategies of a multidimensional approach to increase diversity in the health professions (The Sullivan Commission, 2004). The 37 recommendations are represented by three overarching principles: (1) To increase diversity in the health professions; (2) New and nontraditional paths to the health professions should be explored; (3) Commitments must be at the highest levels of our government and in the private sector (The Sullivan Commission, 2004). Through the work of the Sullivan Commission (2004), the vision for a healthcare system that exemplifies excellence, equal opportunity, and delivery of high-quality care for the entire population may be realized.

A report by Betancourt (2006), supported by the Commonwealth Fund, outlined a framework for both hypothetical and proven strategies for delivery of high-quality, culturally competent care and achievement of equity in healthcare to reduce racial and ethnic disparities in health. The report identified aspects of the cultural competence movement that could be linked to efforts in improving evidence-based quality care for underserved minority populations (Betancourt, 2006). The IOM's report, *Crossing the Quality Chasm* (IOM, 2001) defined "evidence-based practice" as the integration of best research evidence, clinical expertise, and patient values. Betancourt (2006) identified two critical components of cultural competence based on the IOM (2001) concepts of evidence-based practice and patient-centered care. One element will be for systems to be in place that detect health disparities by stratifying measures based on race and ethnicity,

and it will be essential that the systems provide interpreter services for improved communication that allow patients to participate in clinical decisions (Betancourt, 2006). The second element essential to achieve equitable healthcare will be to provide clinical cultural competence that promotes the providers' ability to determine patient preferences and values (Betancourt, 2006). The hallmarks of patient-centered care (IOM, 2001) provide compassion, empathy, and are responsive to the needs, values, and preferences of the person and are central to clinical cultural competence (Betancourt, 2006).

Immigrants in the United States are a rapidly growing minority group of over 36 million people (Derosé, Escarce, & Lurie, 2007) who unfortunately, are subject to limited access and unequal quality of healthcare. "Immigrants have been identified as a vulnerable population, but there is heterogeneity in the degree to which they are vulnerable to inadequate healthcare" (Derosé et al., 2007, Abstract section, para. 1). This statement is supported by a number of factors. Socioeconomic status is a significant factor that contributes to their vulnerability because immigrants are more likely to lack a high school level of education and live in poverty (Derosé et al., 2007). Vulnerability related to immigration or legal status and limited English proficiency are other major barriers to their ability to acquire health insurance (Derosé et al., 2007). Immigrants' vulnerability is also affected by the stigmatization that can occur when there are differences in appearance for example, wearing traditional dress, or if there are differences in religious practices (Derosé et al., 2007). Being part of a stigmatized group frequently leads to reluctance to seek healthcare, longer waits, frustrations, and concerns about poor treatment (Derosé et al., 2007). Understanding the impact of healthcare disparities for persons of vulnerable and minority populations can enable nursing

professionals to provide care that is culturally relevant from the patient's perspective with the aim to promote better health for all communities.

Development of Nursing Theories in Culturally Competent Care

Standards of practice for culturally competent nursing care were developed by a collaborative task force of members of the American Academy of Nursing's (AAN) Expert Panel on Global Nursing and Health and the Transcultural Nursing Society (Douglas et al., 2011). The standards of culturally competent care are based upon the principle of social justice (Rawls, 1971). Social justice is the belief that every person and group is entitled to fair and equal rights, and within this context, have the right to healthcare opportunities (Douglas et al., 2011). The inequities of healthcare disparities can be reduced "through the application of the principles of social justice and the provision of culturally competent care" (Douglas et al., 2011). Today's social justice-based standards of practice reflect the right of all people to receive individualized, holistic, culturally competent nursing care and highlight the relevance of the concept of cultural competence into nursing.

Madeleine Leininger, whose doctoral degree was in cultural anthropology, first introduced the concept of culturally competent nursing care. Relevance of culture care in nursing practice, its importance to nursing research, and the development of the Transcultural Nursing Theory was the life work of Leininger. In the 1950s she began to explore other cultures and study the concept of care and culture through an ethno nursing research approach (Leininger, 1997). Leininger brought about an awareness of the effects of cultural beliefs upon one's approach to their health and illness. Leininger (1967, 1997), in her classic culture research developed the Theory of Culture Care

Diversity and Universality, which essentially states that all human beings experience culture, and those cultures differ vastly from group to group. Leininger also described the subcultures that exist within those groups. She considered culture care an essential service to be provided by all healthcare disciplines, but the genesis of Leininger's research came about because of the realization for the crucial need for nursing to embrace the culture of the patient in order to provide truly holistic nursing care.

Leininger used an ethnography method to immerse herself in other cultures as a participant observer by living among different cultures and made comparisons of these cultures with the American way of healthcare. Leininger (1967) explained how the term *culture* has various usages by different groups, which present a challenge to define the scientific principles of culture, yet it is integral to care for the whole person. For nurses to prevent their own ethnocentric beliefs from interfering with patient care, she stressed the importance to examine one's own cultural beliefs as a starting point to learn how to deliver culturally competent care to people from different cultures. According to Leininger (1967), for nurses to effectively influence the health of others, it is just as vital to consider the person's culture beliefs, as it is to understand the components of their physiological and psychological health. She developed the Sunrise Model (Leininger, 1991) to provide a framework for nurses and researches to utilize in providing "culturally congruent care." A very comprehensive definition of *transcultural nursing* (Leininger, 1978, 1995) evolved from her early beginnings with the concept of culture care; "A legitimate and formal area of study, research, and practice, focused on culturally based care beliefs, values, and practices to help cultures or subcultures maintain or regain their health (well-being) and face disabilities or death in culturally congruent and beneficial

caring ways.” Dr. Leininger continued her work with defining and implementing culture concepts in nursing until her death in August 2012. She will be forever remembered as the founder of transcultural nursing with its influence on the care of humans from all cultures.

Another pioneer of culturally competent nursing care is Josepha Campinha-Bacote. To convey an awareness of health disparities for underserved minority populations she developed a model of cultural competence that identified five constructs that are interdependent and serve as the basis of this model. The antecedent to this model began with her personal experiences of exclusion during the 1960s. Campinha-Bacote is a third-generation Cape Verdean and her interest in culturally competent care came as a result of the early death of her grandfather, who received patient education for his medications that did not take into consideration his background and cultural traditions (Hanink, 2014). She went on to become a nurse and ultimately integrated the concepts of Leininger’s (1978) transcultural nursing, anthropology, and multicultural counseling in her role as a psychiatric nurse. The emergence of this model serves as a framework to guide healthcare professionals through the process of cultural competence.

Campinha-Bacote stressed the “process” of becoming culturally competent and presented the constructs as a guiding path. The *cultural awareness* (Campinha-Bacote, 2002) construct involves a self-assessment to begin the process of cultural competence. *Cultural knowledge and cultural skills* are the constructs that relate to gaining information about the worldview (Campinha-Bacote, 2002) of persons from different culture and then developing the ability to conduct a physical assessment that is culture-based. Another construct, *cultural encounters*, is a vital process whereby the healthcare

provider interacts with culturally diverse clients over a period of time to gain the experience and knowledge to deliver effective care. The utilization of trained interpreters may be required to address language barriers during encounters. The final construct is *cultural desire*, which is the personal drive of the healthcare provider to “want” versus “have to” (Campinha-Bacote, 2002) engage in becoming culturally competent. Dr. Campinha-Bacote developed a measurement instrument, the Inventory for Assessing the Process of /Cultural Competence Among Healthcare Professionals (IAPCC), to measure the model’s constructs, but did not include the construct of *cultural desire*, which the author defined as an area for further research.

The relevance of culturally competent care is important to be equally recognized by all healthcare disciplines involved with the care of the patient. A leader in interdisciplinary instrument development related to culturally competent care is Larry Purnell. The need for a cultural competence model began for Purnell in 1991 when he was teaching undergraduate nursing students. He developed the model as an organizing framework that could guide all disciplines of healthcare to learn to provide culturally sensitive care, although the approach would be uniquely different for each discipline. The significance of a person’s worldview (Purnell, 2005) is related to their cultural influences and differing experiences within the various subcultures. Purnell (2005) makes a distinction between *cultural awareness* as an appreciation of diversity versus *cultural sensitivity* meaning the personal attitudes of the healthcare provider. Interestingly, he stated that culture is unconscious, is learned sequentially in the family, school and then community, and culture has a powerful influence on patients’ health. Several steps outlined the knowledge and skills needed to evolve as culturally competent

and assessment of the patient's race, beliefs and values are vital to implement and individualize the plan of care through the patient's "cultural lens" (Purnell, 2005). Purnell cautions to avoid stereotyping and to explore generalizations with the patient as a beginning step to assess the patient and family's cultural characteristics.

Purnell's model, a grand theory of cultural competence, was based on the metaparadigm concepts of global, community, family, and person. Within the metaparadigm there are 12 domains of culture constructs that provide the principles for culture assessment. Lastly, Purnell identified the primary and secondary characteristics that determine the degree to which a person adheres to their cultural beliefs. The primary characteristics such as color, age, and gender cannot be changed. The secondary characteristics are more diverse and include such variables as occupation, political beliefs, marital status, and sexual orientation to name a few. Overall, Purnell's (2005) model was intended to provide nurses with an instrument to incorporate culture into the nursing process, as well as to engage multidisciplinary professionals in the process of cultural competence.

The cultural models of Campinha-Bacote (2002) and Purnell (2005) were greatly influenced by Leininger's (1967, 1978, 1991, 1995) pioneering model of transcultural nursing care. As the foundress of the worldwide transcultural nursing movement, Leininger's (1995) theory of Culture Care Diversity and Universality provided the concepts of caring and cultural nursing care, which have served as the foundation for culturally competent care in nursing. Campinha-Bacote (2002) built upon Leininger's theory to construct the framework and stages that identified the process of becoming culturally competent for the provision of care with diverse populations. Purnell (2005)

further evolved the work of Leininger by the development of his metaparadigm model for culturally competent care that can be adapted for all disciplines of healthcare professionals. These three cultural competence models have created the humanistic approach of care for people of all cultures into what is today known as culturally competent nursing care.

Theoretical Influence of Culturally Competent Nursing Care on the Care of Patients

Prior to the 1960s there were no specific theories on caring in nursing, recognition of cultures in nursing care, or holistic nursing care (Leininger & McFarland, 2006).

While working in a child guidance center in the early 1950s, Leininger came upon the realization that current healthcare practices were insufficient to help children of diverse cultural backgrounds. Leininger identified the absence of cultural and care knowledge as the missing link in patient care for promotion of compliance, healing, and wellness (George, 2000). To fully understand the connection of caring and culture, Leininger became the first nurse anthropologist by which she integrated the fields of nursing and anthropology, leading to the Theory of Culture Care (Leininger, 1991).

The goal of the Culture Care Theory is to provide culturally congruent nursing care (Leininger, 1995). Leininger was the first to coin the term, “culturally congruent care” which guides the nurse to provide holistic care that is meaningful and relevant to the patient. Leininger defined culturally congruent nursing care as, “those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are tailor-made to fit with individual, group’s, or institution’s cultural values, beliefs, and lifeways” (Leininger, 1995). Human caring is the essence of nursing and care (caring) is essential for a person’s health, well-being, and ability to face handicaps or death (Leininger &

McFarland, 2006). Nurses who practice culturally competent care are able to influence positive changes in healthcare behaviors of their patients from different cultures (Leininger & McFarland, 2006).

The Culture Care Theory provided the foundation for transcultural nursing practice (Leininger, 1995). The new body of nursing knowledge defined three approaches to create care that would be meaningful and helpful to people from particular cultures. *Cultural care preservation or maintenance* indicates nursing care interventions that are in harmony with the individual to retain and preserve their core cultural healthcare values. *Cultural care accommodation or negotiation* refers to creative nursing interventions which help an individual to adapt or negotiate shared healthcare goals that are effective for their health and yet culturally congruent. *Cultural care repatterning or restructuring* are therapeutic nursing interventions that facilitate an individual to change or modify their health behaviors for better outcomes while respecting the person's cultural values. The context of transcultural nursing is ever relevant today as nurses care for increasingly culturally diverse populations. (Leininger, 1991; Leininger & McFarland, 2006).

The *Human Caring Science Theory of Nursing* by Watson (1979, 1997, 1985, 2008, 2012) highlighted the caring-healing role of nurses, the mission of nursing to help preserve humanity and wholeness as the path to health, and nursing's purpose for existence. Some key assumptions of the Human Caring Theory state that the practice of caring is central to nursing, caring can only be practiced interpersonally to be effective, and effective caring promotes health (Watson, 1979, 1997, 1985, 2008, 2012). "Carative" factors as identified by Watson (1997) refer to the aspects of nursing that

“potentiate therapeutic healing processes and relationships” (p. 50). “Whereas *curative* factors aim at *curing* the patient of disease, *carative* factors aim at the *caring process* that helps the person attain (or maintain) health or die a peaceful death” (Watson, 1979).

Watson later coined the term *transpersonal caring* to explain that through the creative use of self, nurses establish human-to-human caring relationships with their patients and engage in caring-healing nursing practice (Watson, 1997). Modalities of transpersonal caring allows us to re-connect professional nursing with the highest tradition of Nightingale’s roots and values (Watson, 1997).

Evolution of Culturally Competent Nursing Care for Diverse Populations

A quantitative study by Marrone (2005) furthered the development of knowledge of culturally competent nursing care. The study examined critical care nurses’ intent to provide culturally competent nursing care interventions for Arab Muslim patients and studied the relationships between the nurses’ attitudes, their subjective norms or beliefs of relevant others, and their perceived behavioral control on their intentions to provide culturally congruent care (Marrone, 2005). Through identification of behavior motivators that relate to nurses’ intention to provide care, a framework could be developed for effective, holistic, and satisfying interventions specific to the culture care needs of the patient (Marrone, 2005). The variables under study were derived from the Theory of Planned Behavior and the data was collected through the use of four Likert-scale instruments to measure each variable. Interestingly, study results revealed significant differences between critical care nurses’ attitudes and their subjective norms, which distinguished subjects who were unlikely to intend to provide culturally congruent care versus those who were indeed likely to intend to provide this type of care to Arab Muslim

patients. Implications of the study suggested the imperative for culture-specific debriefing sessions to examine the relationships of behaviors, thinking, actions, and decisions that affect the vulnerability of Arab Muslims to experience healthcare disparities (Marrone, 2005). Another implication of the study highlighted the necessity of the use of evidence-based cultural approaches to drive nursing education and practice. An important recommendation put forth by this researcher was the further study of factors that influence critical care nurses' intention with the actual behavior of providing culturally congruent care (Marrone, 2005).

Qureshi and Pacquiao (2013) conducted another study that contributed to the evolution of culturally competent nursing care knowledge. Pakistan women who immigrated to the United States were found to experience various difficulties in childbirth care compared to their home country (Qureshi & Pacquiao, 2013). This concept served as the basis for a qualitative, interdisciplinary study by physician, Dr. Qureshi, and nurse researcher and educator, Dr. Pacquiao. The researchers found that "culture has been linked to immigrant birth outcomes and other health behaviors" (Qureshi & Pacquiao, 2013, p. 355). In this study, participants identified the lack of extended kin support, specifically lack of supportive females in the household, as the greatest source of difficulty (Qureshi & Pacquiao, 2013). However, the women studied demonstrated cultural adaptive strategies such as assimilation. Within the new cultural milieu created by assimilation, transformed gender roles of the husband and wife evolved that allowed husbands to take on more active roles in assisting their wives during pregnancy, childbirth, and postpartum, and in caring for their children (Qureshi & Pacquiao, 2013). Implications of the study provided evidence to implement interventions

that should be planned according to the priorities of Pakistani women as in this case, and to provide the accommodation of valued childbirth practices of their culture (Qureshi & Pacquiao, 2013).

Summary of the Literature on the Impact of Culturally Competent Nursing Care

The concept of culturally competent nursing care that serves as the basis for providing holistic, individualized care that is meaningful for the patient has steadily grown over the last fifty years. Particularly in recent years, culturally competent care has gained momentum as integral to the elimination of healthcare disparities for minority and vulnerable populations of diverse cultural backgrounds. Review of the literature emphasizes the importance of culturally competent nursing care that can promote an overall positive level of patient satisfaction. Although the literature suggests a link between culturally competent nursing care and patient satisfaction which could lead to improved health, there exists a lack of knowledge of the patients' perception of the meaning of culturally competent nursing care.

Dimensions of Chinese Cultural Health Beliefs

The majority of nursing professionals in the U.S. has been educated according to the Western views of healthcare and may be unaware of traditional Chinese cultural values and health beliefs. Philosophies of yin and yang, Confucianism, Taoism, and Buddhism provide the foundation for overlapping and interrelated values for Chinese perceptions of health and illness (Chen, 2001; Shih, 1996). In Chinese medicine, diseases may be classified based on concepts of yin and yang as cold or hot disorders (Shih, 1996). The essence of yin and yang is that they are interdependent and provide a

counterbalance to each other that maintain health (Chen, 2001; Shih, 1996). Disharmony of yin and yang leads to pathological changes and the development of disease (Chen, 2001; Shih, 1996). Yin and yang together are the source of life called *Qi* or *vital energy* necessary for health and longevity (Chen, 2001). Health promotion, as well as diagnosis and treatment of illness have been based on the system of *Qi* for thousands of years in China (Chen, 2001).

Taoist tradition advocates following the ebb and flow of nature, guided by simplicity and spontaneity, to find *The Way* (Chen, 2001; Shih, 1996). The cyclical pattern of nature is that once it reaches an extreme, it will reverse back spontaneously (Shih, 1996). Therefore, Chinese usually believe that once their bad luck has passed, their health will recover naturally (Shih, 1996). Being in harmony with nature, with *Tao*, gives peace of mind and physical health (Chen, 2001). For example, walking out-of-doors breathing fresh air promotes health and allows one to be in harmony with nature (Chen, 2001).

The three treasures of Buddhism are mercy, thriftiness, and humility (Chen, 2001). Principles of cause and effect, *Inn* and *Ko*, encourages doing what is right and to do good to others (Chen, 2001). *Inn* and *Ko* have a reciprocal element for one to receive good in return (Chen, 2001). In the Buddhist religious beliefs of health, it is important to give positive meaning to illness and suffering (Shih, 1996). The belief that tolerating the pain of disease will lead to a better reward in heaven after death, illustrates the path for them to reach a higher state in the world of eternal life (Shih, 1996).

Confucian philosophy teaches that to be destined for heaven, one must follow their fate on earth (Shih, 1996). It is also believed that fate is one primary factor that

determines health (Chen, 2001; Shih, 1996). Fate is similar to a net made up of many threads with each thread connected to one another (Chen, 2001). Following one's fate through the fulfillment of their mission on earth and always doing good to others prevents bad luck or illness, leaving a person peaceful, without guilt, and in a state that is supportive of good health (Chen, 2001; Shih, 1996).

Some Chinese people still believe that only Chinese medicine, such as traditional herbs and/or acupuncture, is effective for them (Shih, 1996). However, today Chinese health beliefs in both China and the United States are changing to one that supports a combination of western and traditional Chinese medicine (Chen, 2001; Shih, 1996). A shift is also occurring in western countries with an expanding interest in traditional Chinese medicine and complementary medicine (Chen, 2001). Overall, to provide culturally competent care it is important for nurses to place value on Chinese patients' beliefs of traditional Chinese medicine based on individual preferences (Chen, 2001; Shih, 1996). Expanding a better understanding of their patients' perceptions of health and illness can enable the nurse to implement more meaningful interventions and plan of care for their patients (Shih, 1996).

Experiential Background

The initial interest in the study of culturally competent nursing care began with a curriculum revision project at my place of employment. The school of nursing is located within the city of the Bronx, New York, and is an entity of a proprietary, multi-campus organization. The unique student profile at the College consists of mainly a diverse minority population caring for patients in a very diverse community. As a relatively new

Dean at the College, I discovered some difficulty in articulating the essence of culturally competent nursing care to non-nurse administrators and faculty. Serendipitously, I began doctoral studies at that time and through Dr. Keville Frederickson's faculty mentorship, decided to pursue the topic of culturally competent nursing care for dissertation.

Although the topic of study has been clear, the specific aim to pursue in the study has been an evolutionary and at times nebulous process. Initially interested in cultural competence education for nursing students, the focus changed to measurement of health outcomes resulting from culturally competent nursing care, and finally evolved to the pursuit of understanding the experience of culturally competent care from the perspective of the patient.

With the revised curriculum in place for several years at the College's School of Nursing, the Baccalaureate Community Health Nursing course was expanded to include a clinical study abroad practicum in Fonfrede, Haiti. This afforded me the opportunity to travel with my students and faculty to engage in a medical mission in this rural community with an interdisciplinary team of physicians and public health professionals. My pursuit of the collaboration between the College and a public health organization known as CapraCare, which led us to Fonfrede, was greatly influenced by Dr. Frederickson's previous work in this community of Haiti. We, the members of the U.S. medical mission team, in working with the Haitian team of workers and volunteers, gained insight into an effective approach to develop sustainable community health programs as well as its challenges.

On a personal level, I gained a renewed appreciation for the human spirit. An intervention as simple as a warm compress to one's knee brought a smile and many

words of thanks from someone who had barely enough to survive. The immersion experience of coming into an environment for the first time and unable to speak their language helped to broaden my perspective of the Haitian culture and their ways of health. It became clear to me how culturally competent nursing care is much more than treating people in their community, but rather, it requires nursing care that interacts with the patient, their family, and friends in order to achieve optimum health. As a nurse anticipating to provide culturally competent care in this community necessitated that, I at some level, become a part of their culture and accepted as someone to trust. In reflection of providing care within this culture, I experienced the sense of oneness. All people have the desire for and the right to quality healthcare. Social justice is indeed global justice.

Summary

The impact of diversity and healthcare disparities contributing to the evolution of cultural competence in the U.S. healthcare system was presented. A review of the historical background in culturally competent nursing care revealed the evolution of cultural thinking in nursing and an evolution of several landmark culture care models. The relationship of culturally competent nursing care to the concept of caring, as the core and essence of nursing, was explored. Review of the literature revealed however, that even with the continuous momentum of culturally competent care models for more than 50 years, there is limited qualitative research to provide an understanding of the patients' perceptions of their experience of culturally competent nursing care. This crucial aspect of culturally competent nursing care warranted further study. Health beliefs based upon

traditional Chinese philosophies were presented as essential to understanding Chinese perceptions of health and illness.

Chapter III presents a description of the phenomenological method of research that was used for this study.

“We know not through our intellect but through our experience.”

(Merleau-Ponty, *Phenomenology of Perception*, 1945)

Chapter III

METHODOLOGY: THE PHENOMENOLOGICAL METHOD

This study explored the meaning of culturally competent nursing care as perceived by patients of Chinese ethnicity who received care in a hospital known for being a leader in the delivery of culturally competent care. A phenomenological design was used for this qualitative research to understand the essence of the patient’s experience. Using the approach of phenomenology provided the method to bring to light the Chinese patient’s experience of culturally competent nursing care as it was perceived to be important and meaningful to their health and well-being. This chapter begins with an introduction to the traditional philosophies of phenomenology by Husserl and Heidegger. The chapter also presents the more contemporary philosophies of Merleau-Ponty’s phenomenology of perception and van Manen’s method to conduct phenomenological research to justify phenomenology as an appropriate method for this qualitative study.

Introduction of Phenomenological Research

The purpose of phenomenology is to “understand the meaning of being human” (Munhall, 2012, p. 118). To begin an understanding of this method of research requires the researcher to explore the origins of phenomenology. One of the earliest philosophers, Edmund Husserl, considered the founder of phenomenology, believed that the study of

being entailed a non-empirical approach to study the concept of perception (Husserl, 1900/2014). Husserl was a transcendental phenomenologist because he believed that the way one understands their being is to transcend to “pure” consciousness by bracketing one’s own subjectivity (Husserl, 1900/2014). It is within the epistemology, or knowing of the experience, that we come to understand our being (Magrini, 2012; Reiners, 2012; Stokes, 2008). More specifically, directed awareness of what we experience in the world, which Husserl referred to as “intentionality,” could be achieved through descriptive methods or the process of describing the experience (Husserl, 1900/2014).

In contrast, Martin Heidegger (1923/2005), a student of Husserl, broke from this philosophy by his belief in hermeneutical phenomenology, which aims to interpret the meaning of the experience. His philosophy was ontologically based in that this philosophy presumes that we exist and it is through our interpretation of the understanding of our experiences that we come to know our being (Heidegger, 1923/2005). Based on the idea of ascribing meaning to interpret an experience, the intent of this qualitative study was to use phenomenological methods to explore what meaning culturally competent nursing care has for the patient who has received this care.

Examples of two nursing studies were used by Reiners (2012) to provide a clearer distinction between Husserl’s descriptive and Heidegger’s interpretive phenomenological research. The first study cited by Reiners (2012) was based on Husserl’s descriptive phenomenology. Papp, Markkanen, and von Bonsdorff (2003) conducted a study using Husserl’s descriptive phenomenological philosophy to describe the student nurses’ perceptions of their clinical learning environments. Data was collected via structured and unstructured interviews, as well as observations during clinical practice. Student

reflections of their clinical experiences were taped and transcribed using Colaizzi's method of analysis and the findings were confirmed by the participants. In accordance with Husserl's phenomenology method, researchers used bracketing to set aside any preconceived notions or bias.

The second nursing study cited by Reiners (2012) was based on Heidegger's interpretive (hermeneutic) phenomenology. Idczak (2007) conducted a study to understand student nurses' meaning of their experience of nurse-patient interactions. The researcher, who was an experienced nurse educator understood how students learn in class and clinical, but did not know how they learned the *being of nursing*. Participants were instructed to record their thoughts and feelings of the interactions they had experienced with their patients. The journal entries were interpreted and then separately coded in a priori categories to reveal similar themes. Bracketing was not done because according to Heidegger's interpretive philosophy, "humans are embedded in their world" and therefore the researcher should not ignore their understanding of the subject of study (Heidegger, 1923/2005).

In accord with the foundational phenomenologists, Husserl and Heidegger, this phenomenological study provided the opportunity for the participants to reflect on the meaning of their culturally competent nursing care experience and help to offer nurses insight into the perspective of the patient. According to Munhall (2012), it is the perception of the experience that is most relevant, rather than what may appear to be more truthful. Therefore, what is most important in the human science of phenomenology is what participants perceive from their own personal worldview. Munhall (2012) believes that the nursing profession has an, "ethical and moral imperative

to use phenomenology to foster the highest and most humanistic standards of care” (p. 154).

Merleau-Ponty’s Philosophy of Phenomenology

Merleau-Ponty was educated in philosophy and psychology and was influenced by the German scholars, Husserl and Heidegger (Merleau-Ponty, 1935/1967). His views however differed from the traditional philosophers because he believed that it is through our perception of the lived experience that we have meaning for our existence. Merleau-Ponty became known as an existential phenomenologist and his career was defined by the development of his philosophy as a phenomenon of perception (Merleau-Ponty, 1935/1967).

Merleau-Ponty (1945/2012) believed that one’s perception was based upon their experience with the world. “Let us return, then, to sensation and examine it closely enough such that it teaches us the living relation of the one who perceives with both his body and his world” (Merleau-Ponty, 1945/2012, p. 253). In this context, Merleau-Ponty (1948/1964) uses the concept of “body” to mean the capacity to experience (p. xii). Essentially, it is through the phenomenon of one’s perceptions that we describe the meaning of our experiences (Merleau-Ponty, 1948/1964).

Another important concept of Merleau-Ponty’s (1945/2012) phenomenon of perception was his belief in intentionality, which he described as human connectedness to the world. Husserl’s influence of the concept of intentionality became evident in Merleau-Ponty’s (1945/2012, 315) writings of the *order of coexistents*. Merleau-Ponty’s (1948/1964) new philosophy was grounded on the *relationship of being* as connected in

the world. The intent or attention of humans is always directed toward objects and situations (Merleau-Ponty, 1948/1964). Coexistence then refers to connectedness, which cannot separate the relatedness of the human experience from the directed awareness or consciousness of the experience. Overall, Merleau-Ponty's (1948/1964) phenomenon of perception included human reflection on the meaning of experiences through the intentional and conscious perspective of the event. Most importantly, human connectedness takes on meaning when it is from the perspective of the person experiencing it.

Merleau-Ponty's philosophy was applicable to this qualitative research because the study sought to reveal the meaning of the patient's experience of receiving culturally competent nursing care from the perspective of the patient. In accordance with Merleau-Ponty's phenomenology of perception, the aim of the study was to understand the participant's lived experience. The philosophical framework of Merleau-Ponty was used to guide the study.

Van Manen's Philosophy and Method of Researching Lived Experience

The research method used in this study was based on van Manen's (1990) themes of human science research. Van Manen's phenomenological research method reflects Merleau-Ponty's study of the lived experience. This method is not intended to "prescribe a mechanistic set of procedures" but rather to provide a way to discover the meaning of human experience (van Manen, 1990, p. 30). Van Manen (1990) views his research method of phenomenological research as a "dynamic interplay among six research activities" (p. 30). The following lists van Manen's six techniques:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole.

The first activity according to van Manen (1990), turning to the phenomenon or nature of lived experience, is driven by a commitment of a real person who sets out to make sense of a certain phenomenon or aspect of human existence. Phenomenological research begins with the lived experience and in the end returns to it (van Manen, 1990). In conducting this qualitative study, I sought to understand the lived experiences as perceived by participants of Chinese ethnicity having received culturally competent nursing care.

The second activity according to van Manen (1990), investigating experience as we live it rather than as we conceptualize it, occurs as we ask others to provide a lived-experience description about a phenomenon that the researcher wishes to understand the meaning of. In this study, participants' descriptions of their experience of culturally competent nursing care offered me the opportunity to enter their world to gain an understanding of the meaning of their experience.

The third activity according to van Manen (1990), reflection on the essential themes, which characterize the phenomenon, is done to try to grasp the essential meaning of the phenomenon. Through reflection, the researcher attempts to bring into view that

which is obscure and eludes us in everyday life (van Manen, 1990). “Theme analysis” is the process of recovering themes that are embodied and dramatized in the evolving meanings of the work (van Manen, 1990). My intent for this study was to identify those themes that were personified from the participant’s perspective of the experience of culturally competent nursing care.

The fourth activity according to van Manen (1990), describing the phenomenon through the art of writing and rewriting, is to use language and thoughtfulness to let a phenomenon, an aspect of lived experience, show itself. Human science research requires a commitment to write as writing is the method of phenomenology (van Manen, 1990). In this study, I used the personal experiences of the participants and scholarly references to engage in reflective writing that describe the phenomenon of the lived experience of the participants as recipients of culturally competent nursing care.

The fifth activity according to van Manen (1990), maintaining a strong and oriented pedagogical relation to the phenomenon, is a commitment of the continuing awareness of the relation between research and vocation, between theory and life to examine the question of what is the meaning of. Upon completion of the participant interviews along with the concurrent writings of my own reflections, I then searched for related concepts and theories in the literature that were relevant to the essential themes of the phenomenon.

The sixth activity according to van Manen (1990), balancing the research context by considering parts and whole, means that since the research activity is closely intertwined with the writing activity it is necessary to step back at several points and look at the total and know how each of the parts need to contribute toward the whole.

Through the process of phenomenological study, I transcribed elements of contextual meaning into subthemes, which led to the identification of shared themes that were reflective of the lived experience of culturally competent nursing care perceived by patients of Chinese ethnicity. The process took place over time and required repeated re-examination of participant quotes and re-categorizing of meaning units to arrive at the essential themes of the phenomenon.

The use of van Manen's (1990) method provided the structural framework to investigate, reflect and analyze data, and describe the meaning of the phenomenon as perceived by participants in the study. An analysis of the meaning of the patient's perception of the experience as recipient of culturally competent care may enhance the body of nursing knowledge and provide cultural context to nursing care that is most relevant and meaningful to the patient.

Summary

This chapter briefly reviewed the origins of phenomenology from the German scholars, Husserl and Heidegger. Husserl, known as a transcendental phenomenologist who believed it is necessary to transcend one's consciousness to come to know an experience was contrasted with Heidegger, a hermeneutical phenomenologist who believed it is important to interpret the meaning of the experience so that we may come to know our being. Presented in the chapter were the parallel ideas of Merleau-Ponty and van Manen whose works were influenced by both Husserl and Heidegger. The chapter explored the evolution of phenomenology by Merleau-Ponty, an existential phenomenologist, who believed that it is through our perception of the lived experience

that we have meaning for our existence. Finally, it was explained that van Manen's method of researching the lived experience was used to discover the essential themes for the phenomenon of recipient of culturally competent nursing care as perceived by patients of Chinese ethnicity. The philosophical approach and method of phenomenology was appropriate to utilize in this research of understanding human beings' perceived experiences and provided the element of contextual meaning which served as the foundation for this study.

Chapter IV presents the application of van Manen's phenomenological method of research that was used for this study.

“The notion of ‘lived experience’ announces the intent to explore directly the dimensions of human existence: life as we live it.”

(van Manen, Phenomenology of Practice, 2014, p. 39)

Chapter IV

METHOD APPLIED

This chapter describes the procedure of van Manen’s (1990) method applied in this phenomenological-based study. The phenomenological method of science provides the way to study the “lived meaning” (van Manen, 1990). Lived meaning refers to “the way that a person experiences and understands his or her world as real and meaningful” (van Manen, 1990, p. 183). This phenomenological study was designed to understand the patient’s perspective of culturally competent nursing care among those who have experienced hospitalization in an institution located within a community of diverse populations and that has been nationally recognized as a leader in providing culturally competent care.

Rationale for use of van Manen’s (1990) research method and the aim of the study are provided in this chapter. The criteria for participant selection, sample and setting, access and recruitment, and method are described. The chapter concludes with the procedure to maintain the confidentiality, anonymity, and protection of the human subject participants.

Application of van Manen's Phenomenological Research Method

Van Manen's research steps and methodological themes provide the structure of human science inquiry. This methodological approach however "does not mean that one must proceed by executing and completing each 'step'. In the actual research process one may work at various aspects intermittently or simultaneously" (van Manen, 1990, p. 34). Van Manen (1990) believes that there are no definitive set of procedures to be followed blindly but rather "critical moments" within the research process that depend more on interpretive sensitivity, reflection and thoughtfulness, and scholarly writing. The data provided through use of this research method was obtained from participants who shared their experiences through storytelling. Overall, the techniques set forth by van Manen (1990) are fluid and non-systematic requiring the researcher to proceed in a spirit of inquiry.

Context of the Phenomenon

The purpose of the study was to find meaning and gain understanding of the lived experience of culturally competent nursing care as perceived by the patient. It was not expected that participants would be familiar with the term *culturally competent care*. Therefore, the phenomenon of being a recipient of nursing care, as a person of the Chinese culture, race, or ethnicity as it relates to their experience provided in a hospital nationally recognized as a leader in culturally competent care, has provided focus for the study. The overall aim of the study was to gain the perspective of nursing care experiences from participants, shared through storytelling, as it related to the meaning and importance specific to one's culture.

Selection Criteria for Participants

To be included in the study, participants must have been at least 18 years of age to consent to be a study participant. For this study, one population was selected which required that participants self-identify as being from the Chinese culture, race, or ethnic background. Since participants were asked to share the meaning of their experiences, participants who did not speak and understand English were asked permission to use an interpreter for the interview. Study participants were also required to have had an inpatient length of stay (LOS) of a minimum of four days since the national average LOS is 4.8 days, and as such, is a typical representation of LOS for hospitalized patients (Centers for Disease Control and Prevention [CDC], 2015). Appendix A lists inclusion criteria for eligible study participants.

Sample and Setting

All participants for the study were of Chinese ethnicity who had immigrated to the U.S. from China. The sample consisted of nine participants who were selected from two separate study sites. Six participants for this study were selected from those patients having received nursing care in a hospital nationally recognized for providing exemplary culturally competent care. The hospital site will be designated as *study site #1*. Participants referred by the hospital study site #1 were interviewed in either one of two locations based on participant preference. Three participants were interviewed in their home post-hospitalization. Another three participants were interviewed in the hospital during their inpatient hospital stay prior to discharge.

However, due to long periods of non-recruitment, with approval of my sponsor and the Teachers College IRB, a second study site was selected. The second study site, a Chinese-English church, was obtained through a school colleague who referred a close friend of Chinese ethnicity to assist with recruitment and who was also the Pastor of the church. The church site will be denoted as *study site #2*. The church study site #2 provided selection of the last three participants who volunteered for the study. Participants recruited from the church study site #2, had their nursing care experiences in hospitals other than the selected hospital study site #1. Appendix B provides a diagram for a summary of the study sites interviews.

Study Site #1: Hospital-Referred Participants

The initial, primary setting for selection of participants was the hospital study site #1, which was located within an urban, culturally diverse community. This location was the desired site for study based upon their nomination to receive the first-ever American Hospital Association's (AHA) Equity of Care Award in 2014. The intent of the award was to recognize hospitals that utilized culturally competent care training, were characterized by increased diversity within the organization, and demonstrated ability to lessen healthcare disparities affecting their communities. Genesis of the Equity of Care Award began in 2011 when the AHA joined four national healthcare organizations to issue a call to action to eliminate healthcare disparities. Three essential elements required for nomination of the award included; (1) initiatives to increase the collection of data for race, ethnicity, and language preferences, (2) increased cultural competency training, and (3) increased diversity in the governance and leadership of the organization. It was the aim of this research to gain an understanding of the patient's perspective of culturally

competent nursing care, thus an institution recognized for providing such care and which was located in a community of culturally diverse patient populations provided the ideal location to conduct this study.

It was originally intended that participants selected from the hospital study site #1, would have been a patient on a specific medical-surgical unit, titled by the hospital as the Chinese Unit. Approximately 40% of the patients admitted to the Chinese Unit are Chinese, and the other 60% of patients comprise of persons of Arabic, Caribbean, Hispanic, Italian, Orthodox Jewish, Polish, and Russian cultures. The unit provides a special milieu. For example, certain numbers are not used to denote the room numbers on the unit because they are considered bad luck and the bedside curtains are made of bamboo print signifying good luck. However, special attention to various cultures is widespread throughout the hospital, such as with all the signage is in multiple languages, including Chinese and patients on any unit within the hospital may request Chinese meals.

Due to the persistent long delays in non-recruitment, the study sample expanded to include participants from not only the Chinese Unit but also those who had been a patient on any medical-surgical unit at the selected hospital study site #1. The reason for seeking participants who had been a patient on a medical-surgical unit was that patients on these less-acute care units were more likely to have been fully aware of their complete hospitalization experience. Patients on these units could provide a more in-depth reflection of their nursing care experience compared with those that may have been hospitalized for more acute illnesses such as those admitted to intensive care units.

Study Site #2: Church-Referred Participants

As a result of challenging and prolonged periods of non-recruitment, the church study site #2 was selected. This location was ideal for several reasons. The church was located in a separate but similarly diverse community, which provided a homogeneous sample population. Participants referred by the church study site #2 had also been a patient on a medical-surgical unit, although at different hospitals from the hospital study site #1 participants. This provided an important external secondary-source to triangulate the data identified by participants from the hospital study site #1 for validation of the themes. It was important to continue data collection with the secondary-source interviews because, as described by van Manen (1990), this final and essential corroboration step of the process brings the phenomenological question into view (van Manen, 1990). Other benefits of the church study site #2 were that it promoted an easier process for recruitment because the parishioners were available, they attended church activities on a regular basis that facilitated scheduling of the interviews, and they were feeling healthy since they had not been recently hospitalized as participants from study site #1.

Sampling Method

Purposive sampling of participants who volunteered for this study was used for recruitment of participants. A sample purposefully selected, which is a non-probability sampling technique, is most commonly used in qualitative research as a strategy to select “information-rich” cases where the phenomenon exists (Coyne, 1997). Purposive sampling was an appropriate method for participant selection for this research since the focus of the study was on the meaning of experiences rather than precision and

measurement. This purposeful research design specifically used criterion sampling which involved participant selection based upon those who met certain pre-determined criteria. According to Patton (1990), the point of criterion sampling is to understand individuals or cases that are likely to be “information-rich” because they reveal meaning to the experience and provide focus for the study.

Gaining Access and Recruitment of Participants

Study Site #1: Hospital-Referred Participants

Initial approval to conduct the study at the primary hospital study site #1 had been accepted following three visits in which I had the opportunity to explain my proposed research with Nursing administrators, the Cultural Competence Department administrator, and nursing manager and nursing staff of the Chinese medical-surgical unit. Discussion of the detailed procedure for recruitment of participants was the focus during the initial meetings. Following the preliminary approval to move forward, full approval was sought for the study proposal from the Institutional Review Boards (IRBs) of Teachers College, Columbia University, and the hospital study site #1. However, once IRB approvals were attained, the hospital changed ownership. I was therefore required to apply for a third IRB approval at the hospital that created an additional delay of four months before recruitment of participants could begin.

Participants were informed of the opportunity to participate in the study by recruitment flyers (see Appendix C) that were distributed to patients on medical-surgical units at the selected hospital. It was originally intended that nurses on the Chinese Unit would distribute the recruitment flyers. The rationale for this was that, as is typically

done, nurses provide various written information such as pamphlets, resources, etc. to patients at the time of discharge and the recruitment flyer for study participants would be provided at this time as well. Prior to the start of participant recruitment, I met with the nursing staff working on the Chinese medical-surgical unit to inform them of the purpose and aims of the study and to answer questions related to distribution of the flyers during the time of discharge preparation. This method, however, proved to be unsuccessful in recruitment of participants, which prompted the Vice President for Cultural Competence and Partnership Innovation at the hospital to assign a specific Community Liaison staff within the department to take on the responsibility for recruitment. Additionally, recruitment on one medical-surgical unit created months of delay in recruitment as previously described, so it was proposed by the Community Liaison staff member to expand recruitment to the other medical-surgical units of the hospital, which indeed improved recruitment results.

Those patients who expressed interest in volunteering for the study were requested to provide their phone number so I could contact the prospective study participants, scheduling the first meeting at approximately two weeks after hospital discharge. I rented a phone specifically for the study that was used solely for communication with study participants and their family members. The participants did not speak English, thus the use of an interpreter was used to arrange the meetings and provide information regarding the study. During this initial phone contact with study participants, I provided a detailed discussion related to the specific requirements of the study and the interview process.

If the prospective participant agreed to take part in the study, the inclusion criteria (see Appendix A) were reviewed to ensure eligibility for the study. Eligible participants were informed of the study procedure, which included the requirement that they sign an informed consent (see Appendix D) agreeing to be interviewed and audio-taped during the interview, complete a brief demographic data form (see Appendix E), and participate in an approximately one-hour interview. Participants were assured of their confidentiality regarding all research information. Upon agreement of the terms, mutual agreement of the date and time for the interview was confirmed.

Study Site #2: Church-Referred Participants

Participants referred by the church study site #2 were provided the same process for recruitment as participants from hospital study site #1. The only difference was that these participants spoke English, which eliminated the need for interpreters.

Data Collection Procedures and Sample

Study Site #1: Hospital-Referred Participants

One-on-one, unstructured in-depth interviews supplemented with transcripts of audio-taped interviews, and journaling was used to collect data. A detailed explanation of the study took place with each participant prior to the interview. Signature for consent of the study was obtained following a full review of the informed consent (see Appendix C). Before the start of the interview, the participant was requested to complete a brief demographic questionnaire (see Appendix D) to provide information regarding their age, gender, race, ethnicity, primary language, date and length of stay for last hospitalization, single or multiple hospitalizations, and the reason for admission(s). The demographic

data was used only to describe the group of study participants. The demographic data form (see Appendix D) took approximately ten minutes to complete. Upon completion of the demographic data form, the interview with the participant proceeded.

Participants in both groups of the hospital-referred study site #1, which included the home and inpatient interviews, did not speak and understand English thus an interpreter was used for all interview sessions. Interviews were audio-taped using a digital voice recorder. To promote “information-rich” interviews, a general open-ended question will guide participants to engage in storytelling (Coyne, 1997; Patton, 1990; van Manen 1990). The fundamental question for this study was, “Tell me about your experience as a patient of Chinese ethnicity with the nursing care you received.” Through the technique of storytelling the interviewee provides a lived-experience description for the purpose of hermeneutic phenomenological reflection in order to grasp the essential meaning of the experience (van Manen, 1990).

Study Site #2: Church-Referred Participants

A second data source of the research was originally planned to be obtained from repeated re-interviews of some of the participants. With the progression of data collection, it was not feasible to attempt a second round of interviews. As an alternative as previously described, participants who were not patients in the hospital study site #1, were sought to provide a secondary source to triangulate the data. According to van Manen (1990), an additional source of follow-up to hermeneutic conversations is needed so that the description and interpretation of the experience will be driven by the question, “Is this what the experience is really like?” (p. 99).

Journal Reflections

A third data source for the study was my written journal of personal reflections. A reflection journal can serve several purposes in interview-based qualitative research. Maintaining a journal is one method of reflection that can be used by a researcher to analyze thoughts during the data collection period and ideally should be written as soon after the interviews as possible (Lamb, 2013; Lincoln & Guba, 1985). Qualitative researchers also use journaling during the data analysis phase of the research to “retrace their thinking” which may contribute to the development of new ideas or linking earlier discarded ideas with newer emerging themes (Suter, 2012). For this study, reflections were written within two hours of the interviews and additional reflections were noted during the analysis of the data. The qualitative method of phenomenology does not begin with a theory, but rather construction of theory takes place as the data are being collected (Saumure & Given, 2008; Simon & Goes, 2011). Since qualitative data collection and analysis proceed simultaneously and the researcher serves as the instrument in qualitative research, reflection through journaling can provide credibility and dependability of the findings as well as validity of the study (Lincoln & Guba, 1985).

Interpretation and Translation for Non-English Speaking Participants

Interpreters for the home-interviewed participants from hospital study site #1 were obtained through Alliance Business Solutions LLC Language Services. The company guarantees that all interpreters are HIPPA certified and required to sign a Non-Disclosure Agreement to protect study participant’s confidentiality. Hospital-interviewed participants from hospital study site #1 were done in collaboration with interpreters

employed and trained by the hospital. The hospital ensures that all interpreters pass a fluency test and receive Medical Interpreter orientation, including HIPPA training to maintain patient confidentiality. Translation of the interviews for the English-to-Chinese components was done by the researcher. Back-translation for the Chinese-to-English sections of the transcriptions was done by a native Chinese speaker to ensure consistency of meaning and reliability.

Trustworthiness

The collection of multiple data sources is important to establish the trustworthiness of the research study. Lincoln and Guba (1985) put forth several methods to achieve trustworthiness of qualitative research findings. A single method cannot adequately produce a deep understanding of a phenomenon (Creswell, 1998; Lincoln & Guba, 1985; Patton, 1999). One method to achieve a rich, robust, and well-developed account is through the process of triangulation, which comprises of multiple sources of data in a research study to produce understanding (Creswell, 1998; Denzin, 1978; Lincoln & Guba, 1985; McCutcheon, 2009; Patton, 1999). The goal in triangulation is to understand the data in multiple ways, rather than seeking consensus (Patton, 1999). As previously described, triangulation of data for this study was done using: (a) individual interviews of two groups of participants from the hospital-referred study site #1, namely the home-interviewed post-hospitalization group and the inpatient hospital-interviewed group, (b) secondary-source interviews of participants from the church-referred study site #2, validating the themes as representative of their experience, and who were patients

in hospitals other than the original selected hospital site, and (c) reflection journaling by the researcher.

Another method to establish trustworthiness of qualitative research data is through the process of peer debriefing. This is a process in which the researcher explores aspects of the study with a “disinterested peer” to bring forth ideas that may only be “implicit within the researcher’s mind” (Lincoln & Guba, 1985, p. 308). For this study, I selected a seasoned qualitative researcher, familiar with phenomenology research and van Manen’s method to review the findings to augment the trustworthiness of the study.

Sample Size

Sample size in qualitative research is based on the concept of saturation. Saumure and Given (2008) defined saturation as “the point in data collection when no new or relevant information emerges with respect to the newly constructed theory.” The specific sample size needed to produce robust theory will vary in qualitative studies and is dependent upon the point at which repeated themes occur in the interviews (Saumure & Given, 2008). Van Manen (2014) emphasized the goal of the phenomenology method is not to produce an empirical generalization from a sample to a population. Rather, phenomenology aims to gather enough “experientially rich accounts” to discover what is unique to a lived experience and which can generate a “scholarly and reflective phenomenological text” (van Manen, 2014, p. 353).

Sample size, as determined by data saturation, usually occurs for phenomenological research between 6 and 12 interviews. Albeit, there remains the valid question of “How many participant interviews will be enough?” Guidelines for minimum

sample sizes of phenomenological studies have been set forth by Creswell (1998) as five and by Morse (1994) as six. A quantitative analysis by Mason (2010) examined the sample sizes used for qualitative doctoral dissertations and found that all of the phenomenological studies identified had at least six participants. Guest, Bunce, and Johnson (2006) conducted an analysis of their own research of reproductive healthcare in Africa that included a sample size of 60 women. It was found that of the 36 codes developed from their study, 34 were identified in the first 6 interviews (Guest et al., 2006). It was concluded that, in sample populations with a high level of homogeneity, “a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations” (Guest et al., 2006, p. 78). Thus for purposes of this study a minimum sample size of six was planned as a starting point, but data collection continued for a final sample size of nine. At this point, no new information was forthcoming, recurrence of themes or saturation was achieved, and the narratives were sufficient to describe the phenomenon of study. It is noteworthy, that for this study, all four themes were revealed by the first interview, and then validated by the last three secondary-source interviews.

Confidentiality and Data Storage

To maintain confidentiality, a numbered code system was used to identify each participant's data. The audio-taped interviews were downloaded and emailed for back-translation of the Chinese-to-English sections of the transcripts via encrypted files. Participant information, consent forms, and data have been kept safe in a locked file drawer in the researcher's home. Only the researcher has access to the coded

demographic data forms, coded audio-recordings, and encrypted typed transcripts for each participant. The coded, encrypted transcript files will be stored for 5 years, after which time all participant information will be shredded and destroyed.

Protection of Human Subjects

To maintain protection of the human subject participants, approval was obtained from the Institutional Review Boards (IRBs) of Teachers College, Columbia University, and the selected hospital study site #1. Full disclosure was provided to each participant prior to the start of the interview and included an explanation of the purpose of the study, procedure of the study, risks and benefits, and assurance of anonymity and confidentiality. It was emphasized to participants that their participation in the study was voluntary and they could choose to withdraw from the study at any time. Participants were made aware that they may be given access to audiotapes and transcribed interviews if requested. Each participant was allotted as much time as was needed to ask questions and provide consent for the study. Participants were informed of minimal risk that may occur in discussion of experiences of hospitalization.

Summary

This chapter reviewed the procedure of van Manen's (1990) research method and the rationale for using a phenomenological approach for this study. Application of van Manen's (1990) phenomenological method highlights the progression of critical moments within the research process versus definitive procedural steps. Detailed in this chapter were the criteria for participant selection, sample and setting, access, and data collection

method. The chapter provided an explanation of purposive, criterion sampling that was used for recruitment of participants to obtain “information-rich” understanding that reveals meaning to the experience (Patton, 1990). The process to establish trustworthiness of the study findings was described. Finally, the researcher’s responsibility and procedure to maintain the confidentiality, anonymity, and protection of the human subject participants was explained.

Chapter V will present the findings of the study based upon interviews with nine participants of Chinese ethnicity who shared their stories of the lived experience as a patient having received nursing care and their perceptions of that care related to their cultural values, customs, and health beliefs.

“Phenomenological themes are not objects or generalizations; metaphorically speaking they are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes.”

(van Manen, *Researching Lived Experience*, 1990, p. 90)

Chapter V

FINDINGS OF THE STUDY

This qualitative research studied the phenomenon of receiving culturally competent nursing care as perceived by the recipient of that care; the patient. Nine participants of Chinese ethnicity were interviewed about their experience as a patient receiving nursing care and their perceived specificity of the care to their cultural values, beliefs, and customs. Van Manen (1990) defined the importance of uncovering thematic aspects of lived experiences as “themes have phenomenological power when they allow us to proceed with phenomenological descriptions” (p. 90). The identification of shared themes, which emerged from the participant’s descriptions of their nursing care experiences, is significant so nurses may better understand if their approach to provide culturally competent care is truly perceived by the patient as a valuable part of their care within their cultural context and meaning.

Demographic Portrayal of the Participants and Recruitment Timeline

Descriptive information of the participants provides a view of the patient as a “person” and their experience within a hospital environment for their nursing care. Six of the nine participants spoke only their native Chinese language (Mandarin or Cantonese)

and these interviews thus required the use of an interpreter. Six participants spoke Cantonese and three participants spoke Mandarin. Some participants also spoke Fujianese, a sub-dialect of Mandarin. Appendix F provides specific demographic data of the participants.

The unfolding recruitment process to conduct the interviews took place over 1 year from June 2016 to May 2017. See the Appendix B diagram that illustrates a summary of the recruitment study sites and location of interviews, which were explained in chapter IV. The interviews for each group took place sequentially over time, with the home interviews of study site #1 occurring first, from September through December 2016. The hospital interviews of study site #1 took place next, during one week in March 2017. Finally, the church interviews of study site #2 were conducted over a 2-week period in May 2017. Each group coincidentally consisted of three participants.

Study Site #1: Hospital-Referred Participants

Recruitment of participants was challenging since I am not of the same culture and therefore was very reliant on key persons of Chinese ethnicity to advocate for my study and provide a sense of trust to potential participants. One key advocate was the administrator of the cultural competence department at the hospital where the first six participants experienced their nursing care. Participant recruitment was conducted by one of the community liaisons for the hospital.

Home-Interviewed (three participants). The length of time for interviews that took place in the participant's home after their discharge from the hospital varied widely. All home-interviewed participants and their families were very welcoming to my interpreter and me. They all offered us water or tea. The home interviews were done in

the presence of family members or significant others. At the end of each interview, participants and their families thanked us repeatedly for speaking with them.

Hospital-Interviewed (three participants). The second group of participants also required the use of an interpreter. Each participant in this group, although still hospitalized, was stable and not requiring acute care. The primary difference between these two groups was that since the second group of interviews took place during the participants' hospitalization it was a challenging environment to conduct interviews. Other patients were present behind closed curtains in the semi-private rooms and the participants were generally not feeling well. Similarly to the home-interviewed group, two of the three interviews within the hospital-interviewed second group took place in the presence of family members or significant others. They were also very welcoming to us and thanked us numerous times for taking the interest to help people of their Chinese culture.

Upon completion of the six interviews, the interview process was continued since saturation of themes had not been reached and there were differences in the setting and length of time from hospitalization. However, recruitment stalled for several months. Throughout the data collection period I was re-listening to the audio recorded interviews doing a preliminary review for similarities in data and adding thoughts to my post-interview written journal notations. Although I was beginning to hear similar emerging themes during the interviews and in the audio-recordings, I was still uncertain if I had reached data saturation.

Study Site #2: Church-Referred Participants

The key advocate was the Pastor for the church where recruitment of the last three participants took place. Since it had been several months without any recruitment of potential participants to interview, I contacted several Chinese churches in the same urban community as study site #1, but was unsuccessful in making a connection. Then through a school colleague with a close friend of Chinese ethnicity, I was led to interview the third group of participants. The participants were parishioners from the same Chinese-English church and it was here that I met the Pastor who was supportive of my study. The church was located in another but similar community as the home- and hospital-interviewed participants from study site #1. Both communities consisted of populations with a diversity of minority groups living in an urban setting.

Church-Interviewed (three participants). One principle difference in the third group of participants was that they spoke English and did not require the use of an interpreter for the interview. Speaking directly with participants provided a sense of control and connectivity that was familiar, comfortable, and simply easier. During the interviews conducted through interpreters, I found myself very absorbed in observing the flow of conversation that I may not have otherwise noticed had I understood the language content. At the same time, however, these interviews were frustrating because I could not speak directly to the participants with words. The experience for me was unfamiliar. Although as a nurse I have communicated with patients many times through an interpreter, it was always to just transmit limited, select pieces of information, never to fully engage in meaningful discussion. It forced me to engage in communication on a different level, which led to the use of non-verbal communication between the

participants and me in the form of body language and touching. The sentiment was apparently shared by one participant, Butterfly, who said through the interpreter, “I wish I could talk to you” while she held my hand.

Another primary difference in the interviews, which took place at the church, was that they were done in a private room without family members or significant others present as in most of the previous interviews. It was a delightful experience as the entire congregation welcomed me in a warm, friendly way. I was invited to their luncheon where the church members cooked the meal, prayed together, and enjoyed sharing the meal with one another. Upon completion of the interviews, many of the parishioners thanked me for taking an interest to “help the people of our Chinese culture.”

Demographic Data

Of the total nine participants, there were five males and four females between the ages of 45 to 95 years old. The native language for six participants was Cantonese and the remaining four spoke Mandarin/Fujianese. The length of stay (LOS) in the hospital varied with 2 participants having a short LOS of 4 days, 6 participants with a moderate LOS between 5 to 25 days, and 1 participant had an extended hospital stay of over 30 days. Six of the nine participants had repeated hospital admissions. The length of time between hospitalization and being interviewed varied widely. The home participants were interviewed from 3 ½ weeks to 5 months after discharge. The hospital patients were interviewed having been in the hospital between 4 to 6 days. The church interviewed participants had been hospitalized from 1 to 3 years prior to being interviewed. Appendix F provides a table with the specific demographic data.

Description of Individual Participants and Introduction of Shared Themes

Theme 1: The Nurse's Presence

Home Interview: #01 – *Butterfly*

The hospital Community Liaison made the initial contact with the participant and her family prior to providing me with her contact information. She resided in an Assistive Living facility located near the hospital where she had been admitted. My primary contact was with the Service Coordinator of the facility and there were additional site approvals that I was required to obtain prior to receiving a scheduled date for interview. The interpreter, a young man who I will call Sun Wen (pseudo name), met me at the facility and we were escorted to a waiting area while Butterfly prepared for our visit. During the approximate 30-minute waiting time, Sun Wen and I discussed how to ask the essential question, “Tell me about your experience as a patient of Chinese ethnicity with the nursing care you received.” We also talked about the importance of allowing the participant to speak while providing only sounds or simple words of encouragement, including permitting periods of silence. We briefly discussed the approach for qualitative interviews and that although his involvement was primarily to interpret, I requested he speak as little as possible to provide the participant whatever time she needed to describe her experiences, to tell her story.

The Service Coordinator accompanied us to meet Butterfly and remained present in the room during the interview. She was lively and moved about quickly reminding me of a butterfly. The walls contained beautiful red and gold artwork and throughout the apartment were photographs of the many of her grandchildren. Before the interview

began, she wanted to show me her surgical wound and how it had healed. We began the interview with the essential question, to describe her lived experience of receiving nursing care as a patient of Chinese ethnicity, as stated in the previous paragraph.

Butterfly kept explaining that the nursing care was “good” and “very good”. I then asked questions related to pain, nutrition, and mobility to stimulate her remembrance of the nursing care experience and to provide an easier way for her to talk with us. The first shared theme of the study was revealed when Butterfly was asked, “How did you like the experience with the nurses at the hospital?” She responded, “They were really nice to me. They came to check on me very often and asked what I needed.” The expression of the *nurse’s presence* and *frequently being checked on by the nurse* was described by many participants in the study.

Home Interview: #02 – *Bamboo*

A similar process of contact by the hospital Community Liaison was initiated for the second participant of the study. For this interview, there was a different interpreter who I will call Li Zhu (pseudo name). He was a mature man educated with a PhD, able to speak several languages, and was very familiar with qualitative research. He was born in China, as were all the study participants. When Li Zhu and I arrived at the home of Bamboo, there was no answer at the door but within minutes, there appeared a man walking down the street very slowly accompanied by a woman. This man was the participant who had agreed to interview with me. There were brief introductions outside and then we were invited into his home.

The interview was conducted in an open room centrally adjacent to the other rooms in the home so family members could see and hear us speaking. Present in the

home were his daughter, niece, grandchildren, and a female friend. Initially all family members and significant other were in the same room but after a few minutes, they migrated to the other rooms. Bamboo's friend however remained during the first half of the interview, then said her goodbyes and left. Bamboo sat very still as he spoke and showed me his incisional wound toward the end of the interview. He had been a victim of violence, a knife stabbing, and although he had been discharged 5 weeks earlier, he still had a moderate level of pain. As we spoke, he seemed very strong and stoic which is why I arrived at the pseudo name of Bamboo for him. He had little to say when asked the opening question of what the nursing care experience was like for him. He simply said that it was good and he was satisfied. Therefore, I proceeded with open-ended questions related to pain, nutrition, and mobility to stimulate further explanations. The theme of frequently being checked on was first revealed by Bamboo when he was asked, "For example, how did you express to the nurses if you needed pain medication?" Bamboo answered, "They came to check on me very often."

Home Interview: #03 – Willow

After the third participant was contacted by the hospital Community Liaison, I was scheduled for the interview and with the same interpreter, Li Zhu, as with participant #2. To reach her apartment we had to go down several long winding hallways and a series of stairs, which was sort of like a maze. Once we located the apartment, we were welcomed into their home and seated in the central room of the home, the kitchen. Present during the interview was Willow's husband. Their daughter-in-law who was preparing a meal also remained in the kitchen during the interview but did not speak. Willow was the most recently discharged of the participants, being only 3 ½ weeks post

hospitalization and she appeared to be uncomfortable as she moved about slowly with occasional wincing.

Both Willow and her husband agreed that the nursing care was very good to excellent. When asked what made the experience good, “How did the nurses make you feel good about the care?” Willow explained that the nurses were always there to help with meals and other activities of daily living. She had a soft, whispery voice that made me think of the soft, flowy branches of a willow tree. When she was asked, “How did the nurses know that you needed the pain medication?” She said, “They would come over and ask me.” The dialogue continued, “So they would just come over?” “Yes, they would come very quickly.” Willow’s husband as well stated later in the interview that, “There were times that she wasn’t feeling pain but the nurse would still come over and check on her very often.” This dialogue with Willow and her husband illustrates that the theme of the nurse’s presence is reflected by good nursing care that is characterized by nurses being there “very often” and many times without being asked.

Theme 2: Feeling Understood

Hospital Interview: #04 – *Shu* (Warmhearted)

After the third home interview in December 2016, participant recruitment came to a halt for over 2 months. The hospital Community Liaison and I discussed several times how the primary barrier of trust made recruitment very challenging. Therefore, in March 2017, I took a work vacation and stationed myself in the hospital library each day in the hope of being able to interview hospitalized patients. Fortunately, three of the 5 days there were patients who agreed to interview with me. The interpreters for each hospital

interview were different because they were employed by the hospital so their availability depended on their work schedule and/or willingness to stay after work.

Shu was bedridden, unable to move without feeling pain and required total assistance with activities of daily living except that she could feed herself. She was in a semi-private room with a patient in the other bed. Her daughter and home caretaker were present during the interview. Shu's home caretaker had been with her for 4 years. The second shared theme of the study, *feeling understood* when the nurse did not speak her language of Cantonese, was revealed when Shu was asked, "Was there a time when you were in pain and there weren't any Chinese nurses around to interpret, how did you get the pain medication you needed?" She responded, "They understood me and were very attentive."

Hospital Interview: #05 – Lok (Happiness)

Lok appeared to be healthy; he was not in pain, and was independent in activities of daily living. He was admitted for cardiac disease. He was in a semi-private room but there was not a patient in the other bed at the time. His wife was present and remained in at his side during the interview. The theme of feeling understood was first revealed by Lok when he was asked how he communicated with the nurses if they did not speak Cantonese. He replied, "with movements" and his wife explained that "he will push the button but if they don't talk Chinese then he will point or move around to get the point across to get what he needs."

Hospital Interview: #06 – *Jun* (Truth)

Jun was a 95-year-old man experiencing moderate pain in his right knee and had a fluid aspiration procedure done. He required assistance with many of his needs except he was able to feed himself. As the other hospitalized patients who were interviewed, he was also in a semi-private room with another patient present in the room behind a pulled curtain. Jun was an elderly man whom before and during the interview expressed concern that his affairs were not in order. The interpreter reassured him that he would follow-up with the social worker. When given the option to not participate in the interview, he still wished to do so. Jun was asked how he communicated with the nurses when he had pain. He explained that “They know. If they don’t understand they’ll call the interpreter and so it’s convenient to get an interpreter here if they don’t understand.”

Theme 3: Nice Nurse, Happy Nurse, Happy Patient

Church Interview: #07 – *Wise Owl*

Four months had elapsed since the last interview and recruitment was still unsuccessful in providing any potential participants for the study. Then in May 2017, I was fortunate to have been able to connect with a Pastor of a Chinese-English church that provided the prospect for the third set of interviews at study site #2. The interviews were with parishioners of the church and each participant spoke English. This opportunity provided a dual benefit; it expanded the number of participants for the study and served as a source of external validation for the findings since all previous participants’ experiences were based on nursing care from the same healthcare facility. The

participants for the church interviews shared their nursing care experiences from various hospitals.

The first church interview took place with the Pastor. Although the primary purpose of our initial meeting was to discuss my research and seek his assistance to recruit participants for the study, he wished to share his story. As the Pastor, he had the responsibility of oversight for his congregation and I welcomed his perspective, so I think of him with the pseudo name Wise Owl. When asked about the nursing care he received during the post-operative period after a surgical procedure, Wise Owl identified the theme of *nice nurse, happy nurse, happy patient*. He explained that “Nurses were nice, they were all, ah, professional in treating you and talking to you.” He was requested to explain what he considered professional and he stated that “The nurses were friendly.” Later on in the interview when Wise Owl was describing his mother’s experience as a patient in the hospital he again described the nurses’ approach as “The nurses giving her medicine, ah, talk to her friendly.”

Church Interview: #08 – *Wounded Bird*

Participant #08 was a long-standing member of the congregation and had many hospitalizations for serious medical conditions. His pseudo name is Wounded Bird because he endured much difficulty with his health but even so, he was a survivor and showed strength. He explained the impact of the nurses’ attitude related to the themes of feeling understood and nice nurse, happy nurse, happy patient as he described a nurse’s compassionate approach and of just knowing how to help him deal with his pain.

No I wasn’t able to say anything. I was in a lot of pain, but then, umm, another nurse came in and he, ahh, also a gentlemen, but he is very compassionate because he’s been there for awhile so he knows what it is.

Church Interview: #09 – *Happy Lark*

The last participant interviewed for the study was a vibrant, energetic woman who had long-standing chronic illness from kidney disease in childhood, and then back injury and pain later on in her adult years. Happy Lark is a suitable pseudo name because of her cheerful approach to life in spite of many hardships. Happy Lark identified the theme of nice nurse, happy patient, happy patient as a calming approach when she explained how she felt going into surgery. “I be nervous a little bit, she [the nurse] hold my hand.” She also described this theme as related to the nurses’ responsibility to present a calming attitude; “Yeah even though I’m very sick, you need to calm down the patient.”

Theme Analysis

The process of analyzing lived-experiences as a patient of Chinese ethnicity receiving nursing care, which was described by the participants, began with my listening and re-listening to audio recordings of the interviews to gain a sense for potentially similar thoughts, feelings, and experiences. Once data collection was completed, the process continued through textual analysis as I read and re-read the transcribed interviews looking for meaning units with similarities in words and phrases. Going back repeatedly through the recordings and written transcripts was essential because it is through the study of lived-experience descriptions that we may note commonalities and recurring themes (van Manen, 1990). The process to detect meaning units in the transcripts involved highlighting the texts with color-coded markers, writing reflective words or statements in the margins where the themes and commonalities appeared, and composing lists of similarities. The third activity or technique in van Manen’s (1990) approach to

human science research involves reflection to try to grasp the meaning of a phenomenon. Taking the time to think and write those thoughts with each review of the transcripts was an important part of the process for me, which led to the identification of 10 meaning units. The overall analysis was a fluid process which involved going back and forth between the transcripts and lists until eventually categories emerged that resulted in the three shared themes described above, and a fourth theme of “gratitude” which is explained below. Data results for meaning units became categorized into four shared themes that occurred in 89 to 100 percent of the participants. Interestingly, all four shared themes were described by the first participant interviewed, Butterfly.

Through the use of language, our reflections on the significance of identified themes will allow a phenomenon to show itself (van Manen, 1990). The fourth research activity in van Manen’s (1990) method is to describe the phenomenon through the art of writing and rewriting. Van Manen (1990) explains the importance of writing as the way in which the research is connected to reflections of lived experiences and provides a mechanism to understand “our lived world”. As the researcher, writing provided me with clarity of individual participant experiences as well as a path to see connections of similarly lived-experiences among the participants. In each review of the transcripts, I began to compile lists of sub-themes and participant quotes. Studying participant quotes was a significant step of the process for me because the quotes provided examples that described the phenomenon and helped make it observable. As van Manen (1990) states, “...a phenomenological description is an example composed of examples”. Beyond categorization of examples, I continued to reflect, write, and re-write interpreted meanings that could possibly identify the “essential themes” (van Manen, 1990), those

qualities which make the phenomenon of culturally competent nursing care for patients of Chinese ethnicity what it is.

In the fifth research activity described by van Manen (1990) it is important for the researcher to maintain a strong, continued orientation to the phenomenon in examining the essence of its meaning. The third and last group, church-interviewed participants, provided both an external data source and continued validation of the data findings from the first two groups of home and hospital interviews. External data served as a source of triangulated information since this was the only group that discussed their experiences in receiving nursing care which took place at different hospitals and in different, though similar, communities. Equally as important to the reliability of the findings was the continued validation of shared themes which were present and congruent among the participants in all three groups; the home and hospital interviewed participants' nursing care experiences occurring at the same hospital and the church interviewed participants' nursing care experiences occurring at various hospitals. As I went through the rigorous process of thematic analysis set forth by van Manen's (1990) research activities, I discovered the following shared themes that reveal the meaning of the lived-experience for patients of Chinese ethnicity who received nursing care that they perceived to be important. Table 5.1 provides a brief summary of subthemes and related participant quotes for each identified shared theme.

Table 5.1

Identified Shared Themes with Related Subthemes

Theme	Subthemes	Participant Quotes
Theme 1: The Nurse's Presence	1A: The nurses checked on me "often". 1B: The nurse's quick response. 1C: The nurse being there.	1A: They came to check on me often; the nurse visits me frequently; they came to my room very often and asked how I felt; the nurses were very attentive and asked what I needed. 1B: I asked and they did it right away; they respond fast. 1C: She was with me all the time; I wake up and she next to me.
Theme 2: Feeling Understood	2A: The nurse understands. 2B: Non-verbal communication. 2C: Communication with an interpreter.	2A: They understood me; she just knew; the nurse knew what I meant; he knows what it is. 2B: I used body language to point with my hand; I would point to where it hurt; you see my face, the emotion. 2C: If I don't understand they call an interpreter; they're always ready to translate when I need it.
Theme 3: Nice Nurse, Happy Nurse, Happy Patient – with its impact on one's perception of their health	3A: The nurse was nice, friendly, happy, and cheerful. 3B: The nurse was helpful and showed concern.	3A: They were attentive and cheerful; they were very nice to me; the nurses were friendly to me; if I see the nurse face serious...maybe I die soon. 3B: Took care of me very well; very considerate; show compassion.
Theme 4: Gratitude	4A: Thankful for the nurses. 4B: Thankful to the researcher.	4A: I appreciate all the nurses did for me. 4B: Thank you for helping the Chinese people.

Theme 1: The Nurse's Presence

One commonly shared theme discovered from the study was the theme of the nurse being there and frequently being checked on by the nurse. Most participants in the study described the nursing care as very good because of the nurse's frequent presence at the bedside. The phrase, "the nurse checked on me often" was used repeatedly in many interviews. Participants explained that they may not have called for the nurse but the nurse would just come to ask how they were feeling or if there was anything they needed. In particular, there was the mention of the nurses' presence, of being there often without being asked to come and which participants described as providing a level of comfort for them. The quick response time of the nurse was also an element identified within this theme.

Subtheme 1A: The Nurses Checked on Me "Often". Butterfly explained several times throughout the interview that she appreciated the nurses because they provided good care for her, which she described as the nurses frequently coming into her room to check on her.

They came to check on me very often... They came very often, sometimes two nurses together to help me... They constantly came in and checked on me and asked what I needed.

Jun stated that the nursing care was very good and described how the nurses had been very helpful.

They come check on me often and it makes me feel more comfortable... The nurses visit me frequently and see if I want anything, if I need any help. It shows they care about me.

Subtheme 1B: The Nurse's Quick Response. Shu related the level of good nursing care in terms of response time. "The level of care that they provide is great. They treat me very well, very helpful... Whenever I need something, they would bring it to me right away."

Bamboo identified the quick response of the nurses a few times during the interview when explaining different needs that arose during his hospitalization.

They came to check on me very often... They gave me everything I asked for. Very responsive. If I needed pain medication they gave it to me right away... I asked them to clean the bowel and they did it right away.

Wounded Bird felt the response time of the nurses was important and he provided an exemplar of unfavorable response time as the physical needs and acuity level of the patient is reduced.

You know you spend 14 days in the hospital and more or less you see the same nurse a couple of times... And basically the response, if you look at it, if you plot a response time as the day go by, in the beginning, because of your situation, you just came out of surgery, they know they have to respond to you relatively fast. But after a while then you are talking and moving around, they don't respond to you as much.

Subtheme 1C: The Nurse Being There. Willow recalled her experience in the intensive care unit (ICU) as receiving very good nursing care primarily because the nurses were present and attentive.

The Chinese nurses were great, very attentive... All the nurses were very good (non-Chinese)... I remember one nurse very well. She helped me to take a bath and got changed when I was at the ICU when I have very low blood pressure. She was with me all the time.

Happy Lark described her experience of undergoing surgery and how the nurse being there made a difference. "I be nervous a little... Like when I go to surgery, they

hold my hand and say, ‘when surgery finished I be with you’ and I wake up and she next to me... I feel comfortable.”

Theme 2: Feeling Understood

One of the most universally shared themes revealed was the concept of feeling understood by the nurse when they did not speak the same language. For all participants in the study, the ability to communicate with the nurse was of utmost importance and many spoke of the use of interpreters during their hospitalization. Participants also described how they communicated with nurses without the assistance of an interpreter. Specifically, it was identified that the ability of the nurse to simply understand was a typical occurrence before seeking the assistance from an interpreter. Many of the participants stated the phrases, “the nurse understands” and “the nurse just knew”. The use of non-verbal communication primarily with body language was also essential to being understood by the nurse who did not speak their Chinese language and was effective in many situations as perceived by the patient.

Subtheme 2A: The Nurse Understands. Shu talked about how the nurses helped her to manage her pain, which was usually communicated with a nurse who spoke her Cantonese language. However, Shu also acknowledged that she still received the pain medication she needed even though there was not a nurse available who spoke Chinese as illustrated in the following dialogue.

Was there a time when you were in pain and there weren’t any Chinese nurses around, did you get the pain medication you wanted?

Yes.

Did it take a while for you to get it?

No. They understood me and are very attentive.

How did you tell her you wanted pain medication?

She just knew.

Butterfly expressed her lament over not being understood. “No one understand me here since I can’t speak any English. I tended to repeat the same thing again and again.”

Bamboo had an interesting way to communicate to the nurse when he had pain. “I hummed and the nurse would interpret it as ‘hurt’.” This was explained to me by the interpreter that the humming gave a similar pronunciation as the word “hurt”.

Subtheme 2B: Non-Verbal Communication. Willow described how she communicated with the nurses who did not speak her Mandarin language.

I used body language with my hand. They understood me. They know what I meant... They would come over and touch the part that they thought it might hurt and asked me if that was right.

Lok stated that he communicated to the nurses “...with movements.” His wife explained in congruence with her husband that “...if they don’t talk Chinese then he will point or move around to get the point across to get what he needs.”

Subtheme 2C: Communication with an Interpreter. Bamboo similarly stated how at times he communicated with body language “...by pointing to where it hurt.” However, he explained there were other times when he was in need of an interpreter. “Every time when I was confused or didn’t understand they called for an interpreter.”

Lok was independent in his activities of daily living such as eating, bathing, and ambulating. He never made mention of nurses frequently checking on him; however, he did discuss about communication with the nurses because he did not speak English. Lok

described the nursing care as good and when asked what made the nursing care experience good, he explained it in the following way.

They're always ready to translate when I need it... Most of the time the nurse that comes in can usually speak Chinese or they will call someone to come in who can speak Chinese... Sometimes they use the phone to translate but it's difficult because they talk too quickly or the sound is too distant so it's hard to hear.

Communication was not a direct priority for the church-interviewed participants since they all spoke English but interestingly they still discussed the issue when explaining their perspectives of the nursing care. Happy Lark stated that she did not experience any difficulty in communicating with the nurses and described an additional component of non-verbal communication even though she can speak English.

No, no problem with the language because if you see I'm pain, you see my face. And if you give me something to eat that I don't eat, like steak, you see my face, the emotion. Yes you watch the face and see the emotion.

Wise Owl likewise spoke English and could communicate with nurses easily, but he did describe the concept of the nurse understands when discussing the hospitalization of his mother.

My mom I guess they understood what she needs. Some of us, my brother, my sister, and myself was there to interpret sometimes but the nurses know what she needed.

Theme 3: Nurse's Caring Behaviors – Nice Nurse, Happy Nurse, Happy Patient

Another generally shared theme that became evident from the findings of the study was the theme related to the caring behaviors of the nurse as being nice and happy. This concept was most important to their health and well-being. All participants in the study described what characteristics they considered as desirable related to the nurses'

approach, which influenced whether they felt supported and cared for versus apprehensive and frightened. Many descriptors were used to define the optimum caring behaviors presented by the nurse that was considered most therapeutic as perceived by the patient, but explicitly, if a nurse assumed a serious approach it was considered a sign that the patient was not doing well and may not recover.

Subtheme 3A: The Nurse was Nice, Friendly, Happy, Cheerful and the Impact on One's Perception of Their Health. Butterfly repeatedly expressed how nice the nurses were to her.

They were very nice to all the senior patients in the hospital... Oh they were really nice to me... They were very patient and don't feel bothered at all with the fact that I had to come back to the hospital again.

Wise Owl described the friendliness of the nurses both in circumstances when he was a patient and with his observations of when his mother was in the hospital.

Nurses were nice, they were all, ah, professional in how they treated you... The nurses were friendly to me... The nurses caring for my mom talked to her friendly, not a problem with that, with the nurses.

Lok and his wife talked about the attitude of the nurse as most helpful if they were in a happier mood or that they have a more cheerful personality. They described the importance of the nurse's caring behaviors on the perception of his health.

If I am suffering and I see the nurse as more happy, then I can see that happiness and reflect off of that and feel more happy... Some of the nurses coming in are not in a very happy mood or are too serious. ...when you are sick feeling horrible, and then the nurse looks miserable, so then you feel like you're in a terrible situation. I think I might die.

Happy Lark similarly described the importance of the nurse to portray a happy attitude with its impact on the perception of her health.

Uh, I need the nurse to be happy and say ‘what’s wrong’ or ‘it’s okay, the doctor be here’. If I see your face happy it helps. If I see the nurse face serious, I think maybe the nurse upset with me. Yeah, maybe I die soon!

Subtheme 3B: The Nurse was Helpful, Considerate, Showed Concern,

Compassion. Wounded Bird explained that compassion is important for the nurse to show to the patient because they have the knowledge and experience to anticipate what the patient will experience. He presented his point with the following example.

Nurses know this,...they might know that your gonna have a headache. If I punch you in your nose, I know how you gonna feel. But if you never got punch in the nose before, you never know, you don’t know how it feel. So, at that perspective...this is where your compassion, you have to understand. Okay, what I feel is something totally new.

Butterfly described how the nurses treated her with a good attitude.

They were all polite and had good attitude... The nurses helped me... They were very patient with me... They showed great concern and took care of me very well... They were all very nice. They gave us blankets if the temperature was cold. Very considerate.

Theme 4: Gratitude

Gratitude was expressed from various perspectives by the participants. Overall, all participants and their families hoped the information they provided for the study could be used to improve nursing care for patients of their culture; for a collective good. Many of the study participants thanked me repeatedly at the end of the interviews. Other participants provided specific reasons for expressing gratitude.

Subtheme 4A: Thankful for the Nurses. Willow stated, “I appreciate all the nurses did for me.” Wounded Bird explained his gratitude by saying, “You know you

want to thank everyone of them [nurses], even those one who I telling you about. I want to thank every one of them for taking care of me.”

Subtheme 4B: Thankful to the Researcher. Butterfly thanked me for “...doing such good deed for the elderly people. Thank you very much again.” Jun expressed gratitude as “Thank you, thank you. Thank you for helping the Chinese people.”

Summary Statements by the Participants

The essential question of this phenomenological study was “Tell me about your experience as a patient of Chinese ethnicity with the nursing care you received.” It was discovered early on in the study that participants found this question difficult to answer so each interview began with a more general opening question. “What was your experience like being a patient in the hospital?” This led to participant discussions of pain, food, and mobility. A second question was asked early on in the interview, and repeated several times throughout was “Can you describe what the nursing care was like?” “If you please, can we go back to the nursing care and describe how the nurses made you feel?” At the end of each interview participants were asked one last overall question as an attempt to reach the core of the patient’s perspective of culturally competent nursing care. “So, if I am a nurse caring for a patient who is of Chinese ethnicity and since I am not of the Chinese culture, what should I know to provide the best care as they would expect? What would be most important for the nurse to understand?”

Several responses described a concept that had not been mentioned earlier in the interview as illustrated by the following quotations:

Bamboo explained that “I feel it should be the same. ...it would be the same level of standard and approach.”

Wounded Bird expressed what was most important as “Nurses need to forget who they are. By that I mean, if I am a nurse I need to forget that I am Chinese, I need to forget that I am white. And just care for the patient.”

Happy Lark described what a nurse needs to understand. “You do it your way, because you’re the professional. Don’t listen to me. You understand? Because if I say I want orange juice but no good for me, don’t listen to me. You understand? Do what is good for me.”

Observational Finding: A Shared Experience related to Family-Centered Care

An essential observation that began to emerge was that of a “shared experience” between the patient and family or significant other person in their life. Initially during the interviews with family members present, I felt a sense that the participant was not provided a full opportunity to express their views and that the family member was speaking for them. After re-listening to the recordings and reading the transcribed interviews, I was surprised to discover that in fact, the participants did describe their experiences and feelings without being interrupted. An example of the discussion with Willow and her husband illustrates their shared perception of the nursing care experience.

Willow stated that “Nurses were great, very attentive” and her husband followed with saying, “they were very considerate and responsive,” then Willow, “nurses were very good” and her husband reinforced the thought, “very good.” Willow’s husband explained, “The nurses helped her getting up,” Willow added, “they took my blood, took blood pressure, helped me with the bathroom” and her husband added, “helped her with food.” Willow and her husband, almost together said, “All the nurses were nice” and “yes every one of the nurses was nice.”

There seemed to be a cohesiveness revealed in the discussions and that the participant and their family or significant other was very connected. As I started to notice this, it appeared that they were answering together, like a dance. My previous perceptions of family-centered care were that it is essential to include family/significant others into the plan of care as the patient desired, but I always believed that the patient and their family experienced the hospitalization differently, each from their own perspective. Interestingly, through this study I came to a contrary realization that the essence of family-centered care may not simply be involvement of family but something more. There was a synchrony in the hospital experience for the participant and their family. The conversations had a rhythm, almost musical in quality. This was evident in how they answered questions and at times, it seemed to include the interpreter. The patient's and family's perceptions of the nursing care and overall hospital experience was in synchrony. My understanding became that the patient and their family or significant other had a shared experience.

Family-centered care supports the family's need for information, reassurance and support, and to be near the patient throughout the healthcare experience (Henneman & Cardin, 2002). Implementing select interventions, such as open visitation, does not ensure an effective approach to family-centered care, but instead requires time, patience, and a philosophy of family caring by a committed nursing team (Henneman & Cardin, 2002). For the Chinese family, there is a highly group-oriented approach that emphasizes loyalty and a strong belief to maintain the harmony of the family (Carteret, 2010; Chen, 2001). Chinese families are devoted to the care of their loved ones because as a patient, they are considered weak, vulnerable, and in need of help and protection (Shih, 1996).

Therefore, Chinese families feel it is their duty to meet the needs of their loved family member experiencing illness (Chen, 2001; Shih, 1996).

Interpretative Statement

The findings of this study provided perspective on the experience of nursing care by patients of the Chinese culture. The notion of connectedness was an overarching theme within each of the four identified themes and was revealed in varying aspects of their nursing care experiences. It was evident as a physical, safety, and comfort connection in the theme of nurse's presence. A psychosocial connection within the patient-nurse relationship manifested in the theme of feeling understood. There manifested a more complex connection in the perception of one's health related to the nurse's caring behaviors in the theme of nice nurse, happy nurse, happy patient. Lastly, there transcended a higher sense of connection in the thankfulness expressed for the nurses and researcher in the theme of gratitude. The following statement captures the essence of the participants' lived experience of nursing care from their unique cultural perspective.

The experience of nursing care by participants of Chinese ethnicity as patients in a hospital nationally recognized for providing exemplary culturally competent care is one where the nurse's presence resulted in being understood with a feeling of nice nurse, happy nurse, happy patient and feelings of gratitude for the nurses. When these factors were blended, participants felt a connectedness and shared experience with both their family and the nurses.

The significance of connectedness was also displayed by the strong, close-knit ties to family, particularly in the "shared experiences" of nursing care expressed by family members during interviews. As immigrants from China, some of the study

participants and their family members shared personal hardships they endured to arrive in this country. It was clear how they never lost their sense of culture, which maintained a longitudinal thread to their identity. A participant's statement that illustrates the importance of the nursing care experience to be connected to their cultural identity was best expressed by Wise Owl as he described what was most important for a nurse to understand when caring for a patient of Chinese ethnicity. "...learn the culture. Understand the culture, how they think and how they see, ah, how they communicate, you know."

Summary

This chapter presented the data findings revealed through the qualitative method of interviewing participants to examine the lived experience of being a recipient of culturally competent nursing care. The recruitment process and demographic portrayal of nine participants of Chinese ethnicity were described. Identification of four themes were presented: (a) nurse's presence; (b) feeling understood; (c) nice nurse, happy nurse, happy patient related to nurses' caring behaviors and the impact on one's perception of their health; and (d) gratitude. Analysis of the shared themes and their related sub-themes were detailed and which included supporting participant quotations. In addition, the researcher's observational findings highlighted a primary theme of shared experience by the patient and their family and/or significant others and its relation to family-centered care for Chinese families. The chapter concluded with an interpretative statement based on the notion of connectedness.

Chapter VI will present a synthesis of the data with implications for nursing practice, education, and future research.

“Culture is the arts elevated to a set of beliefs.”

(Thomas Wolfe)

Chapter VI

ANALYSIS OF THE FINDINGS

This qualitative research study was undertaken to explore the meaning of culturally competent nursing care experience by individuals of Chinese ethnicity. Analysis of the data was guided by van Manen’s (1990) methodology of phenomenological research. Gaining insight regarding aspects of nursing care that the patient believes to be most important to meet their healthcare needs provided significance to the study. Understanding the patient’s perception of nursing care will guide nurses to provide care that is individualized, holistic, and relevant to the patient.

Four essential themes identified in this study, which the participants expressed as most important aspects of nursing care, were: (a) nurse’s presence; (b) feeling understood; (c) nice nurse, happy nurse, happy patient reflected by the nurse’s caring behaviors’ influence on the patient’s perception of their health; and (d) gratitude. This chapter will provide a synthesis of the data with a discussion of the themes based on literature, as well as, utilization of the theoretical framework of Human Caring Science Theory of Nursing by Watson (1979, 1997, 1985, 2008, 2012) to assist with the provided theoretical context. Through this discussion, the researcher will seek to understand culture-specific approaches of nursing care that can be most beneficial as defined from

the perspective of the patient. The chapter concludes with nursing implications, limitations and strengths of the study, and future recommendations.

Synthesis of Data and Literary Findings

Theme 1: The Nurse's Presence

The concept of the nurse's presence is a well-known nursing care construct essential for effective nursing practice. Theories that define the impact of the nurse's presence on positive patient outcomes have continued to evolve from as early as Florence Nightingale who defined nursing presence as a *rare healing presence* (Dossey, 2000). A literature review of current studies revealed that nurse's presence continues to be an enduring topic of study. A concept analysis study by Hessel (2009) focused on presence in nursing practice and the results supported the importance of nurse's presence theories with the following description:

Considered a valuable part of the human experience for both the patient and the nurse, exploration into presence in nursing practice can strengthen connections between the nurse and patient and can uncover therapeutic benefits for patient healing and recovery. (p. 276)

Leininger's (1967, 1978, 1991, 1997, 2006) classic culture care studies that evolved through collaboration with other transcultural nurse researchers to determine what were the most important elements of culturally congruent care resulted in a list of 175 Care Constructs that were discovered from the study of 58 cultures. These qualitative research studies based on Leininger's (1991) theory of Culture Care Diversity and Universality used ethnography methods to study participants in their natural living

environments. The resulting Care Constructs were derived from the dominant culture values and care meanings seen within the various cultures.

Presence, or *being with*, was included in the list of Care Constructs and was identified as a value of universality that is similarly shared among cultures (Leininger & McFarland, 2006). The nurse *being there* was a recurring theme as one of the 10 most frequently identified universal care constructs of Leininger's Culture Care Theory (1978, 1991). "*Care as presence* is often deeply valued and promotes therapeutic outcomes" (Leininger, 2006, p. 286). The data findings related to the theme of nurse's presence for the participants in this study, which included the nurse being there frequently and often without being asked, correlated with the earlier findings of Leininger's transcultural studies as an important aspect of nursing care viewed from the perspective of the patient.

Nurse's presence was an element within Parse's (1981, 1992, 1995) Human Becoming Theory. This theory is based on the construct of human being's living health and the role that nurses can take to empower people to achieve healthy behaviors (Parse, 1995). Parse's Human Science Theory of Nursing was constructed from a synthesis of philosophies from the nursing theory of Rogers' (1970, 1986) known as the Science of Unitary Human Beings and from some of the most prominent existential phenomenologists such as Heidegger (1962), Merleau-Ponty (1974), and Sartre (1966). Parse defined health as a synthesis of values unfolding through man's lived experiences of being and becoming. Nursing was defined by Parse (1981, 1992, 1995) as *true presence* with the other to promote health and the quality of life. Through a synthesis of concepts, Parse (1989) put forth a set of fundamental principles that are essential for practicing the art of nursing. Some of the theory's tenets specifically relate to presence,

or being with, and include the importance of connecting with others, valuing the other as a human presence, and being available to others (Parse, 1989).

A parallel correlation of nurse's presence for the participants in this study is most closely aligned with Watson's (1979, 1997, 1985, 2008, 2012) Human Caring Science Theory of Nursing. Watson's theory involves a blend of science and caring which provides the basis for nursing practice. "Nursing/caring science as a focus has to work at changing its lens to see anew and appreciate some of its beauty, art, and humanity as well as its empirical clinical science" (Watson, 2012, p. 11). Yet, caring in nursing is unlike traditional sciences and requires its own lens to see the meanings, relationships, and context of caring phenomena (Watson, 2012). Watson (1979) created a framework of Carative Factors to distinguish the values, knowledge, and practices of human caring in nursing. The carative factors are complimentary to medicine and at the same time are a contrast to the focus of cure in medicine versus care in nursing (Watson, 1979). As Watson's theory of human caring continued to emerge, the carative factors evolved to Clinical Caritas Processes, which defined an expanded model of transpersonal caring (1997, 2008, 2012). Nurse's presence, defined as a caritas process (1979, 1997, 1985, 2008, 2012) of *authentic presence*, is an integral and overall encompassing concept of caring in nursing.

Theme 2: Feeling Understood

Florence Nightingale (1860/1969) observed in her writings, "How little real sufferings of illness are known or understood" (p. 102). A review of the literature revealed that the concept of feeling understood, contrary to nurse's presence, has seldom been explored, particularly in the nursing literature. Within the field of Psychology, there

exists a larger core of research studies that have examined the concept of feeling understood. These studies have been within the context of interpersonal relationships, human motivation, social support, and subjective well-being. According to Morelli, Torre, and Eisenberger (2014) past studies reveal that both personal and social well-being are outcomes of individuals' feeling understood. Morelli et al. (2014) however identified a gap in studies on the neurobiological basis of feeling understood. Their research method used a combination of behavioral sessions and MRI scanning to determine if feeling understood would activate the rewards centers in the brain. It was interesting to note that the analysis of this study suggested that feeling understood increases interpersonal closeness and MRI scans showed that neural responses to feeling understood demonstrated significant activation in regions of the brain related to reward and social connection.

For the participants in this study, there was a link between feeling understood and social connection, which was apparent in two ways. First, it was clear how important family members and significant others were in their participation in the interviews to tell the stories of their shared experiences that was described in Chapter V, Observational Findings section. Second, at the conclusion of the interviews many of the participants thanked me, not for themselves, but for the collective good of others in statements such as “thank you for helping the elderly people” and “thank you for helping the Chinese people”.

Similar to the theme of nurse's presence, Watson's (1979, 1997, 1985, 2008, 2012) Human Caring Science Theory of Nursing captures the essence of the theme in feeling understood for the participants in this study. The *caritas* process of *authentically*

listening to another person's story involves listening to achieve a deeper knowledge and understanding of one's illness/health experience (Watson, 1997, 2008, 2012). Authentic listening occurs with the nurse being present and supportive of the expression of positive and negative feelings that provides "...a connection with deeper spirit of self and the one-being-cared-for" (Watson, 2008, p. 34).

The Role of Acknowledgement in the Themes of Nurse's Presence and Feeling Understood

The *caritas* processes previously described as delineated in the Human Caring Science Theory of Nursing (Watson, 1979, 1997, 1985 2008, 2012) represent the principle themes of nurse's presence and feeling understood as revealed by the participants in this study. These two themes are particularly evident in Watson's (1983) cross-cultural studies of human caring among Anglo Saxons and Aborigines in Australia and Chinese in Taiwan. The cross-cultural data classified nurse's caring as *Bioactive*, by which the patient-nurse relationship is expressed with kindness, benevolence, and responsiveness (Watson, 1983). The data also classified caring by the nurse as *Biogenic*, whereby there is a truly life giving presence by the nurse to be open and giving from the heart, showing compassion and dignity to create a human-to-human trusting relationship (Watson, 1983). The cornerstone of human caring is greater than classifications of nurse's actions and is represented "as ideals and directions toward desired actions of being and doing" (Watson, 2012, p. 45). Caring within the context of culture is based on respect and with the nurse's approach openly receptive with deep respect (Watson, 2012).

Respect is conveyed through the act of acknowledgement (Tomm & Govier, 2007). The communication of acknowledgement to another person can be expressed through non-verbal gestures or body language, but is usually conveyed by words (Tomm & Govier, 2007). Tomm and Govier (2007) differentiated between two types of acknowledgement. First, the act of acknowledgement indicates the recognition of the person's existence or *existential acknowledgement*. In the process of existential acknowledgement, a person expresses the recognition that the person exists and is worthy of consideration. The other form of acknowledgement, *affirming acknowledgement*, occurs when a person values the acknowledgement that is given.

This connection between the provider and recipient of acknowledgement, as in the therapeutic relationship between the patient and nurse, facilitates the process of nursing care to assist the patient in achieving positive health outcomes (Hessel, 2009; Leininger, 1978; Parse, 1981; Watson, 1979, 1997, 1985, 2008, 2012). The idea of "connection" to improve patient health has been conceptually identified as *respect* (Leininger, 1978), rare healing presence (Nightingale, 1860 as cited in Dossey, 2000), true presence (Parse, 1981), and authentic presence and *transpersonal caring moments* (Watson, 1979, 1997, 1985, 2008, 2012). A recent qualitative-design study found a similar benefit of the nurse-patient connection through partnership-based nursing practice, which assists patients with chronic obstructive pulmonary disease in finding motivation to achieve better health (Leine, Wahl, Borge, Hustavenes, & Bondevik, 2017). One of the key themes revealed from the participants' experiences was to be seen, talked with, and understood (Leine, et al., 2017).

Acknowledgement is fundamental for promoting and maintaining human wellness (Tomm & Govier, 2007). In the process of providing culturally competent care, a nurse essentially acknowledges the importance of the patient's cultural values and health beliefs as an integral part of who they are as an individual. When the positive effects of existential acknowledgement overlap with affirming acknowledgement, and when it is person-centered, acknowledgement will contribute to the recipient's psychological and emotional well-being (Tomm & Govier, 2007).

Theme 3: Nice Nurse, Happy Nurse, Happy Patient Related to Self-Perception of Health Status

The concept discovered by the third identified theme, referred to as nice nurse, happy nurse, happy patient, was a unique characteristic of "good" nursing care as revealed from the participants in this study. A variety of adjectives were expressed by participants to describe what characteristics of the nurse's caring behavior were important to them and to differentiate between "good" and "not good" behaviors. Some of the most frequently cited descriptors of nurse's behavior that were considered beneficial to their care included nice, friendly, happy, cheerful, helpful, caring, considerate, showing concern, and compassionate. Participants viewed these characteristics of nurse's behavior not only important to their trust and sense of well-being, but several participants felt strongly that the nurses' behavior was a reflection of their health status. Several study participants explained that if the nurse appeared to be serious, then their condition must be serious and they may "die". Likewise, it was perceived by some study participants that if the nurse appeared cheerful and happy, then their condition must be improving and they would regain health. This was a particularly unique finding of this

study of participants of Chinese ethnicity that highlighted the relationship of patient's perception of nurses' caring behavior and its impact on the patient's perception of their health status.

Our values and attitudes are the essence of how we live as humans and translate how nurses provide humanistic care to patients. Similarly, ones' values and attitudes affect how a person views their health and what benefits they gain from being a recipient of nursing care. What becomes most relevant then are not solely the caring behaviors themselves, but rather how caring behaviors are translated within the context of the patients' perception, interpretation, and relevance to their care. The essence of the nice nurse, happy nurse, happy patient theme identified in this study explains how caring behaviors provided by nurses can result in important patient-nurse relationships. This theme also illustrates how establishing congruence between patient perceptions and nurses' caring behaviors become essential to deliver nursing care this is meaningful to the patient's perception of their health referred to as self-perception of health status.

Theme 4: Gratitude

Study participants conveyed the expression of gratitude for various reasons that included their contribution toward the study results, which could be used for a collective good to help others within their Chinese culture. Another source of gratitude was for the nurses who provided their care regardless of whether they considered the care "good". Several of the participants also expressed gratitude to participate in the study so it may help the care of the elderly. All the participants were grateful to me, as the researcher, for taking the time and interest to meet with them.

In China, saying “thank you” is seen as a formality, creating a barrier to personal relatedness and genuine gratitude (Robertson, 2014). Baumgarten-Tramer (1938) categorized types of gratitude as verbal, concrete, or connective gratitude. Verbal gratitude, simply saying “thank you,” and concrete gratitude, a way to repay by offering a material object, are more associated with American culture (Baumgarten-Tramer, 1938). Connective gratitude is a value-based form of thankfulness which is “...defined as the beneficiary’s positive feeling towards the benefactor and the recognition of an obligation to repay, if at all possible, with something deemed to be of value to the benefactor” (Baumgarten-Tramer, 1938, p. 21). Connective gratitude is more aligned with the Chinese culture based upon the Confucian philosophy of social relationships (Wang, Y.C., 2014; Wang, D., Wang, Y.C., & Tudge, 2015).

The precise nature of the concept of gratitude for the participants within this study remains unclear. The theme of gratitude was not necessarily in response to the guiding question of the study, “Tell me about your experience as a patient of Chinese ethnicity with the nursing care you received.” Even so, it was undoubtedly reflected by participants and their families as an essential element of their value system and who they are as an individual within their Chinese cultural life.

Summary of the Themes with Schematic Representation

In an attempt to coalesce the themes revealed in this study, the following diagram illustrates the relationship of direct nursing care needs and nursing-influenced needs that were identified by the participants of Chinese ethnicity. The themes of nurse’s presence and feeling understand are viewed as an interconnecting, dynamic process which occurs

through provision of direct nursing care needs. The two processes lay a foundation for gratitude to evolve as caring is provided with genuine respect and concern, and a relationship is built upon understanding and trust. Patient perceptions or views of their health as revealed by the theme of nice nurse, happy nurse, happy patient, is referred to as a nursing-influenced care need that may result from the nurse's caring behaviors, primarily communicated by non-verbal approaches in the care of the patient.

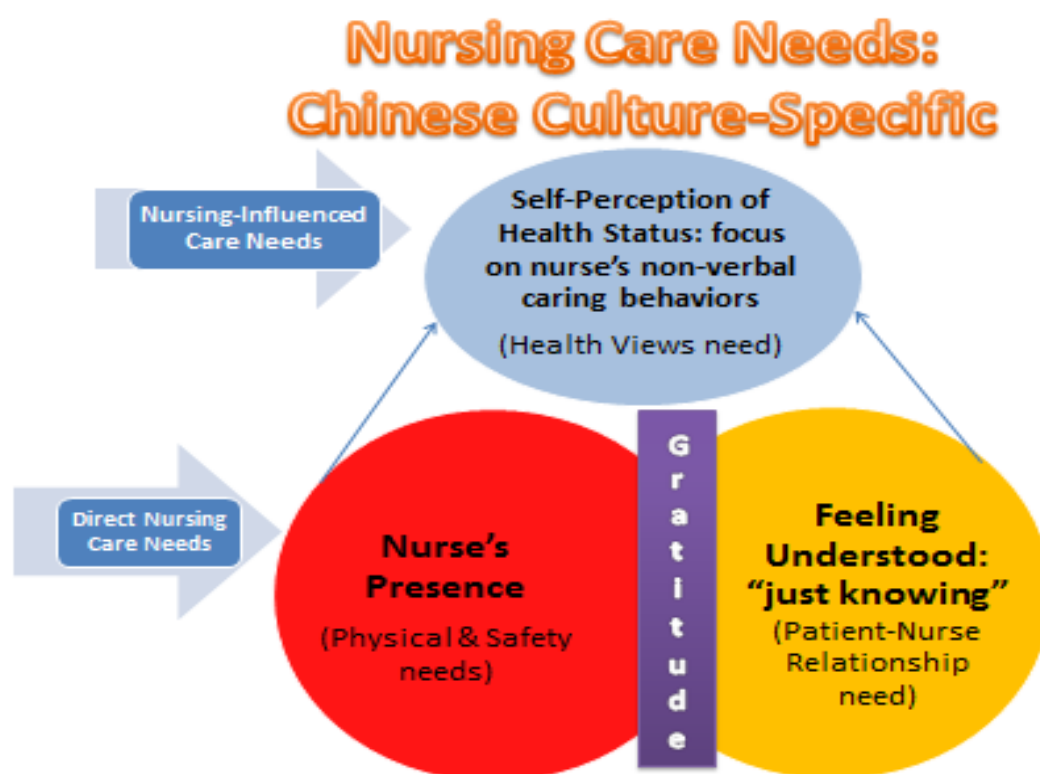


Figure 1: Schematic Representation for Summary of the Themes

The theme of the nurse's presence as described by the participants in this study correlated with the Physiological and Safety levels within Maslow's (1954) Hierarchy of Needs. Study participants reiterated how the nurse coming in frequently to check on

them provided opportunity to have basic needs met that included food, water, warmth, and pain relief, but also gave them a sense of comfort. The sense of comfort conveyed by some participants was particularly highlighted through explanations of how at times, they did not have any specific needs, but the nurse was always there. Many participants explained the nurse's presence not only in terms of the frequency with which they saw the nurse, but they believed the nurse being present was an indication that the nurse really cared. Participants' belief of the nurses' caring was clearly expressed by Jun. "The nurses visit me frequently and see if I want anything, if I need any help. And it shows they care about me."

In providing basic physical and safety needs, the nurse communicates either through verbal or non-verbal ways to establish the unique patient-nurse relationship. Therefore, one does not precede the other and it is through the nurse's presence that there develops a bond, which can result in the patient feeling understood. Through descriptions provided by study participants, the theme of feeling understood revealed the importance of the patient-nurse relationship and the relevance of the communication within this dyad. For the participants in this study, feeling understood by the nurse was a result of either verbal and/or non-verbal communication that at times described a unique knowing between them. Participants explained how the nurse simply understood in such phrases as "they understood me; she just knew; the nurse knew what I meant; he knows what it is."

The Nice Nurse, Happy Nurse, Happy Patient theme exemplified the nurses' influence in the patient's perception of their health for the patients of this Chinese culture. As study participants described, if the nurse exhibited happy caring behaviors

there was a perception of recovery and return to health versus when the nurse exhibited serious caring behaviors that would indicate poor recovery or even death. The study participants gave the strong sense of the importance of self-perception of one's health as a key determinant of health in insightful statements, such as, "if I see the nurse face serious...maybe I die soon." Therefore, health views or perceptions were a significant need for the participants of this Chinese culture and may constitute a higher-level need representing a hope for recovery and return to health.

Theoretical Context of the Findings

Application to Watson's Human Caring Science Theory of Nursing

Authentic presence is enabling and sustaining to the subjective life world of the one-being-cared-for (Watson, 1979, 1997, 1985, 2008, 2012). The process of authentic presence creates the opportunity for transpersonal caring moments. The concept applied to nursing care defines a caring occasion/caring moment as when two people, the patient and nurse, come together in a human-to-human transaction that is meaningful, authentic, intentional, and honoring the person and which results in a shared human experience that expands each person's worldview and spirit (Watson, 1979, 1997, 1985, 2008, 2012). This encounter can lead to new discovery of self and new life possibilities providing the opportunity for improved health outcomes for the patient (Watson, 1979, 1985, 2012).

Watson (2012) emphasizes the importance of intentionality and sensitivity by the nurse of "...holding another person's story for them" (p. 47). Through compassionate being and listening "...the nurse is helping to put the patient in the best condition to access his or her own inner healing resources" (Watson, 2012, p. 75). Watson references

this process as consistent with “...Nightingale’s model of putting the patient in the best condition for nature to heal” (Watson, 2012, p. 75). In essence, Watson’s (2008, 2012) theory views the value of nurse’s sensitivity in authentic listening as a “caring consciousness” to make a human connection through perception of other’s feelings, fostering a feeling of being understood, and promoting the human capacity to regain health.

To be human is to feel. Nurses who are sensitive to others are better able to learn about another’s view of the world which, subsequently, increases concern for others’ comfort, recovery, and wellness. (Watson, 2008, p. 34)

The participants in this study gave descriptions of good nursing care reflected by nurses frequently being there which correlated with the fundamental essence of the patient-nurse relationship elucidated by Watson’s theory. Watson’s (1979, 1997, 1985, 2008, 2012) theory reveals not only the importance of presence to build the patient-nurse relationship but also highlights the reciprocal human need for the presence of one another. A value system for human caring set forth by Watson (2012, p. 46) “...requires a high regard and reverence for a person and human life...” The value of reciprocity in the patient-nurse relationship, described by Watson (2012), is a situation in which both the patient and the nurse perceive and experience illness within the context of meaning for their experience that goes beyond the illness itself. Watson (2012) emphasizes the dimension of nurse’s presence as one in which “The nurse is viewed as a coparticipant in the human caring-healing process. Therefore, a high value is placed on the relationship between nurse and other” (p. 46), contributing to a path that can guide the patient toward positive health outcomes. Watson (2012) reflects the nurse’s presence and caring as a moral ideal that transcends the action itself:

The ideal and value of caring is clearly not just a thing out there but is a starting point, a stance, an attitude, a consciousness, that becomes an intentional commitment and a will toward “seeing” and being present with loving, caring consciousness manifesting in concrete doing and being. (p. 41)

Examining the concept of caring in nursing may provide an understanding to the link between nurse’s caring behaviors and patient’s perceptions of their health. Caring is the essence of the unique domain of nursing (Fawcett, 1989; Leininger, 1984; Parse, 1981; Watson, 1979). Fundamentally, caring is reflected through nurses’ behaviors. There is an abundance of nursing literature on the relevance and importance of nursing behaviors that reflect caring (Finfgeld-Connett, 2008; Kyle, 1995; Patistea, 1999). The concept of caring involves a complex process of interactions within the patient-nurse relationship (Papastavrou et al., 2012). Nursing interventions, reframed by Watson (2012) as Caring-Healing Modalities, involves processes that embrace “...all ways of knowing for human caring” (p. 89). Nurse’s caring behaviors and its impact on the patient’s self-perception of their health is exemplified by Watson’s (1979, 1997, 1985, 2008, 2012) theory of human caring with its intricacies of ways of knowing:

Caring requires knowledge and understanding of individual needs; knowledge of how to respond to others ‘needs; knowledge of our strengths and limitations; knowledge of who the other person is, his or her strengths and limitations, and the meaning of the situation for him or her; and knowledge of how to comfort, and offer compassion and authentic presence; and to hold another in his or her wholeness, while he or she is vulnerable, hurt, wounded and suffering. (p. 89)

An important assumption of human caring by Watson (2008) is that to effectively develop a sense of humanity requires that the nurse demonstrate and practice caring by identifying ourselves with others. Watson (2008, 2012) has defined this concept of caring for humanity by the Caritas Process of cultivating sensitivity to one’s self and others that can lead to an authentic transpersonal presence with the patient. An important

component of cultivating sensitivity can be developed through meaningful rituals for practicing gratitude (Watson, 2008, 2012). In making the correlation between Watson's (2008, 2012) approach to cultivate sensitivity for gratitude and Baumgarten-Tramer's (1938) definition of connective gratitude, it is interesting to note the element of reciprocity that must occur for genuine, authentic gratitude to exist.

Overarching Theme of Connectedness

The notion of connectedness described by the Interpretive Statement in the preceding chapter was evident in each theme identified by the study participants. The thread of connection with the patient begins with the nurse's presence providing care that is authentic (Watson, 1979, 1997, 1985, 2008, 2012). Watson believes that as the nurse strives to practice and develop sensitivity to others within themselves, the nurse can become more authentic. The connection within the patient-nurse relationship must be genuine in order to create a caring environment in which the patient is feeling understood and that is conducive to the restoration of their health.

Connecting with patients as described by Watson (1979, 1997, 1985, 2008, 2012), referred to as authentic presence and transpersonal caring moments highlights the importance of connectedness within the patient-nurse relationship to promote positive health outcomes by restoring harmony and health.

The nurse's ability to realize and accurately detect feelings and the inner condition of another...can occur through authentic presence, being open, intentional, and mindful with actions, words, behaviors, cognition, body language, feelings, thought, senses, intuition, and so on. (p. 76)

To restore health, Watson (2012) views the science of caring as complementary to the science of curing. It is through the connection with humanity that nursing care can

promote optimum healing for the patient. In consideration of the nurse's caring behavior reflected by the theme of Nice Nurse, Happy Nurse, Happy Patient, the patient's perception of their health can be influenced by the nurse as regarded through the following description by Watson (2012):

A nurse may have access to a person's mind, emotions, and inner self indirectly through any sphere – mind, body, or soul – provided the physical body is not perceived or treated as separate from the mind and emotions and higher sense of self (soul). This is consistent with Hippocrates, who thought the person's mind and soul should be inspired before illness could be treated. (pp. 62-63)

Personal Reflections on the Research Journey

In reflection of how nurses gain the art of connectedness, I believe that overall, it is the desire of the nurse to want to engage whole-heartedly in the special healing relationship between the patient and nurse. It is the nurse's consciousness and intentionality to be present in transpersonal human caring moments that drives the connection for feelings of care and compassion (Watson, 2012). Watson (2012) wrote a poem of her phenomenological research experience in 1982 with an Aboriginal tribe in Western Australia on "an overnight train ride back to civilization in Perth" (p. 107). She found that writing of the poetry itself was a transcendent experience (Watson, 2012). As I look back on this research journey and my attempts, frustrations, and agonizing periods of waiting, I was inspired by Jean Watson to write my personal reflections as a poem. The following is a reflection of my personal experience in getting to connect with this extraordinary group of participants.

Letting-In... to Understand the Nursing Care Needs of Chinese Culture

I asked, to let me in?

IN, now I feel unfamiliar and trying to know how to connect, how to understand

How unfamiliar is your world? everyday, since you left the homeland to find a new home

IN, not understanding your words, still, I see

I see...How important it is to preserve your culture, traditions, values, beliefs

I see...Gratitude

Loneliness

Pain

Fear of dying

Fear of growing old

Wisdom

Humiliation

Happiness

I see your family bond, holding on

I see your hope, to let me in

so we can begin, to understand, to know how to help best, to help you heal

You will not be forgotten as the ones to open your world, to let me in.

Now, I am beginning to know...

If I am there, present, to care for you and comfort you;

If I am there, to listen, so you feel understood;

If I am there, happy, so you feel hopeful and optimistic for recovery, return to health;

Then I can be there for you, for the whole of you.

Thank you, to let me in.

Implications of the Study

Implications for Nursing Practice

The primary implication of this study for nursing practice is that it highlights the importance for the nurses' perspective to be closely aligned with the patient's beliefs of what nursing care needs are most important to their health and well-being. Persons of each ethnic group bring a unique perspective of values and health beliefs to their nursing care experience. Through this qualitative study, patients of Chinese ethnicity verified certain known elements of holistic, individualized nursing care, and others were newly brought to light.

Participants confirmed the importance of nursing care to meet their basic physical needs for pain control, mobility, nutrition, comfort, and safety measures through the frequent presence and caring of the nurse. Study participants also confirmed the importance of the patient-nurse relationship to establish elements of trust, comfort, and safety, with inclusion of family and significant others. Study participants revealed the true value of the patient-nurse relationship is that it should result in a sense of feeling understood. Overall, an implication for nursing practice is that the frequent caring presence of the nurse and a patient-nurse relationship that establishes genuine caring, respect, and feeling understood are of primary importance.

An important recommendation for nursing practice is for nurses to assess their own knowledge of Chinese philosophies, values, and health beliefs and then to validate the patients' perceptions of health and illness. However, in learning about a culture, nurses must avoid stereotypes and treat each patient as an individual (Kleiman, Frederickson, & Lundy, 2004). Specifically for Chinese families, a family-centered

approach will provide the family opportunity to meet the needs of their loved ones, giving the patient a feeling of security that is vital to promote a sense of well-being and integrity of the family.

Interestingly, the newly illuminated concept of the nurse's influence on the patient's perceptions of their health provided an important glimpse into the perspective of patients of Chinese ethnicity regarding nurses' caring behaviors. In order for nursing care to have an impact on positive health outcomes for their patients, it becomes essential to gain an understanding of the patient's health beliefs within the context of their cultural beliefs. It is equally as important for nurses to gain an awareness of caring behaviors and its influences on patients' views of their health, particularly when caring for patients of Chinese ethnicity.

Another key implication of the findings of this study is that it supports previous research and theories of culturally competent nursing care by Leininger (1967, 1978, 1985, 1991; Leininger & McFarland, 2006). Culturally competent care in healthcare is not a new concept and particularly within nursing, culturally competent care has undergone an evolutionary process of integration into nursing practice from as early as Leininger's first identification of transcultural nursing as a result of her ethnonursing research beginning in the 1950's. Today standards of practice established by major organizations including The Institute of Medicine (IOM, 2001, 2002, 2004, 2011), Office of Minority Health (2001), The Joint Commission (2011), and American Association of Colleges of Nursing (AACN, 2008) provide the foundation for culturally competent care. The findings of this study provided standards of expectations from the viewpoint of

patients of Chinese ethnicity that can broaden the effectiveness of culturally competent nursing care.

Most importantly, the Human Caring Science Theory of Nursing by Watson (1979, 1997, 1985, 2008, 2012) provided a theoretical framework for the findings of the study. The themes of nurse's presence, feeling understood, caring behaviors effect on the patient's perception of their health, and gratitude directly correlated with the theory's concepts of caring, authentic presence through transpersonal caring moments, authentic listening as a caring consciousness, human need for the patient-nurse relationship, and cultivating sensitivity through meaningful rituals for practicing gratitude (Watson, 1979, 1997, 1985, 2008, 2012). The enduring elements of caring through connection within the patient-nurse relationship is the cornerstone of nursing practice that provides holistic, individualized nursing care, conducive to health and healing (Watson, 1979, 1997, 1985, 2008, 2012).

Implications for Nursing Education

The integration of culturally competent care concepts into nursing curricula has steadily evolved for more than 30 years. Course content, teaching methodologies, and evaluation of learning of culturally competent care in nursing education progressed from the research and theories of Leininger (1967, 1997), Campinha-Bacote (2002), Purnell (2005), and Jeffreys (2013). Today's foundational nursing education standards for culturally competent care have been set forth by the American Nurses Association (1986), The Institute of Medicine (IOM, 2002, 2004), California Endowment (2003), and American Association of Colleges of Nursing (AACN, 2008). Yet there is not a

standardized approach to teach cultural competence in nursing education (Campinha-Bacote, 2006).

Although there is a lack of consensus for a specific standard to teach cultural competence, nursing students generally are taught to obtain a cultural assessment of their patient. An important implication of this study is to build upon the initial cultural assessment and gain a deeper understanding of the patient's perspective of nursing care needs as the nurse develops the patient-nurse relationship. It is essential for nursing faculty and students to acknowledge that competency in cultural care nursing is not a destination, but a journey of ongoing transformation within the nurse that occurs when the nurse has the desire and actively engages with persons of different cultures (Campinha-Bacote, 2006; Leininger, 1967, 1997; Watson, 1979, 1997, 1985, 2008, 2012). The foundation for cultural nursing competency begins in pre-licensure nursing programs and continues into years of nursing practice just as the nurse gains expertise with other aspects of nursing care.

Watson's Human Caring Science Theory of Nursing (1979, 1997, 1985, 2008, 2012) provides the foundation for understanding the essence of nursing care at all levels of nursing academia. Using the set of beliefs and concepts by Watson's theory to stratify patient care needs may allow the nurse to provide a culture-specific approach to care for the patient and facilitate the nurses' understanding of nursing care needs from the perspective of the patient. In conducting patient assessments, the initial assessment is used to establish a baseline and is an essential component of the assessment to begin connectedness with the patient. Similarly, just as with any other aspect of patient assessment, comprehensive cultural assessment requires ongoing engagement with the

patient to validate culturally competent, individualized, holistic care that is specific to the patient's values, customs, and health beliefs. This approach provides perspective, validation, and prioritization of the nursing care needs that can be specified for a culture, sub-culture, community, family, or individual.

Limitations of the Study

A limitation of the study was the use of a convenience sample purposely selected to achieve similarity in the cohort of participants where all participants were immigrants from China and were recipients of nursing care in hospitals within similar urban communities. As such, the findings from this sample cannot be generalized to the overall population. Another limitation of the study was that it only examined the lived experience of culturally competent care by participants from one culture. A specific limitation of this study was the researcher's language barrier to speak Cantonese or Mandarin, creating challenges to recruitment of participants, as well as the need to use interpreters for two-thirds of the participants. The language barrier was particularly challenging for this researcher as a novice to the phenomenological method of research.

Strengths of the Study

A primary strength of the research is that it examined the nursing care experience from the perspective of the patient. An additional strength of this research is that it examined the lived experience of persons of Chinese ethnicity, a population not frequently studied. The participants' willingness to provide an emic viewpoint gave a

valuable contribution to the body of nursing knowledge in caring for patients of the Chinese culture.

Future Areas of Research

There has been a multitude of research on various aspects of culturally competent nursing care but limited studies have examined the patients' perceptions of their experience of cultural nursing care. The results of this study, using a qualitative phenomenological approach with patients of Chinese ethnicity, provided an understanding of patients' perceptions of nursing care experiences that they considered valuable and important within the context of their culture and health beliefs. The findings identified the patients' perceived nursing care needs for participants of Cantonese and Mandarin cultures. The study results can serve to expand the nursing knowledge base for effective approaches to deliver meaningful nursing care experiences for patients of this culture and perhaps those of other cultures.

One area for further study identified by this research is to examine the concept of feeling understood as revealed by participants in this study. Some questions to explore may include how the patient's sense of feeling understood evolves within the patient-nurse relationship. What are some of its defining characteristics? What nursing care approaches can facilitate feeling understood by patients of different cultures?

Another area of study resulting from this research is to investigate the relationship of patient perceptions of their health status influenced by nurse's caring behavior. What other influencing factors may affect one's perceived views of their health? How do factors that influence one's health views vary among different cultures?

An additional recommendation for further research is to replicate this study with patients of other cultures and ethnicities. Gaining knowledge of patient perceptions of their lived experience of culturally competent nursing care can promote a greater understanding of the phenomena as perceived by patients of differing cultures. Exploration into the meaning of culturally competent nursing care as perceived by patients from the myriad of cultures represented in our diverse communities would expand the foundation for nursing knowledge to deliver holistic, individualized care that is congruent with the patient's values, customs, and health beliefs.

Summary

This chapter presented a synthesis of the data for each of the identified themes of the study: (a) nurse's presence; (b) feeling understood; (c) nice nurse, happy nurse, happy patient interpreted as the patient's perception of their health influenced by the nurse's caring behaviors; and (d) gratitude. Study findings supported by previous research and theories specifically related to nurse's presence were detailed (Leininger, 1978, 1991, 2006; Parse, 1981, 1992, 1995; Watson, 1979, 1997, 1985, 2008, 2012). The role of acknowledgement was discussed in relation to the themes of nurse's presence and feeling understood. A summary of the themes and schematic diagram were presented to blend the participant perceptions of their nursing care experiences. All themes were linked within the theoretical framework of Human Caring Science Theory of Nursing by Watson (1979, 1997, 1985, 2008, 2012). Application of Watson's human caring theory was correlated to the overarching theme of connectedness as identified within each of the themes. Implications for nursing practice and nursing education, limitations and

strengths of the study, and further areas of research were explored. Replication of this study with participants of differing cultures was recommended.

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Appendix A

Inclusion Criteria for Eligible Study Participants

<i>Criteria</i>	<i>Met</i>
1. Participants self-identify as belonging to the Chinese culture, race, or ethnicity.	
2. Inpatient hospital stay on a Medical-Surgical unit.	
3. Overall inpatient hospital stay for a minimum of 4 days.	
4. Can speak and understand English or are willing to speak through an interpreter.	
5. Age greater than 18 years.	

Appendix B

Summary of Study Sites Interviews

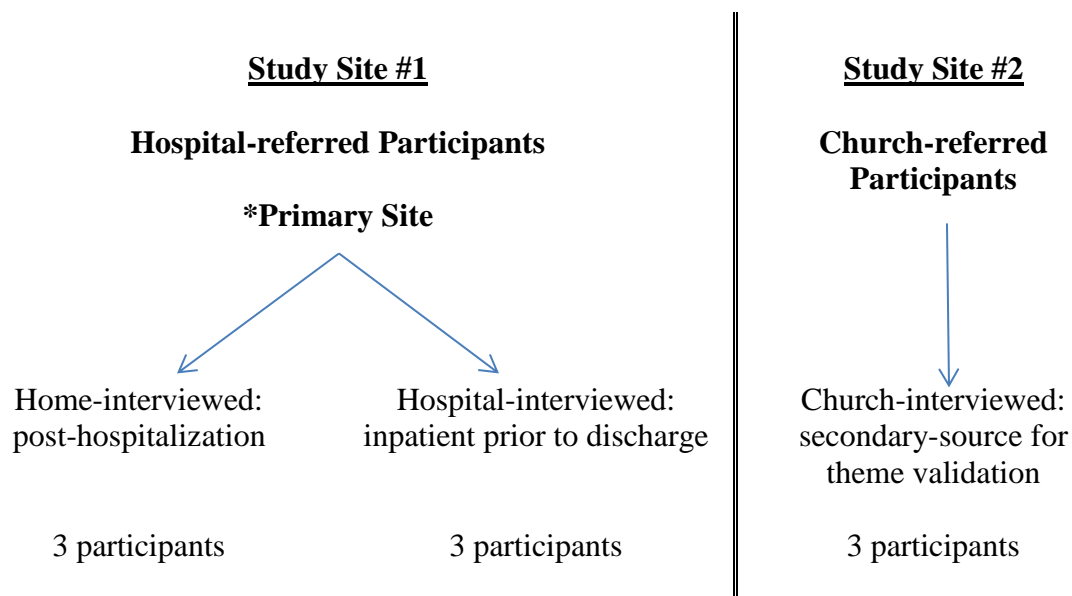


Figure 2: Diagram - Summary of Study Sites Interviews

Appendix C

Recruitment Flyer for Study Participants

STUDY ON THE EXPERIENCE OF CULTURALLY COMPETENT NURSING CARE AMONG PATIENTS OF THE CHINESE CULTURE

A research study is being done by a nurse who is a doctoral student at Teachers College, Columbia University. The purpose of the study is to gain an understanding of patient perceptions and meaning of their nursing care experiences by those of Chinese culture, race, or ethnic background.

To take part in the study you must be...

- ❖ From the Chinese culture, race or ethnic background
- ❖ A previous patient that was in Lutheran Hospital
- ❖ A previous patient that was in Lutheran Hospital for at least 4 days or longer
- ❖ Able to read and speak English or willing to speak through an interpreter
- ❖ Age greater than 18

What does this mean for me?

- ❖ All information learned from you will be kept CONFIDENTIAL
- ❖ This study involves filling out a brief questionnaire and taking part in a private tape-recorded appointment
- ❖ The entire study will take less than 90 minutes
- ❖ You will receive \$25 as a thank you for your time and participation in this research study!



Contact Deborah Little, RN at 201-232-2509 for more information

Appendix D

INFORMED CONSENT

Teachers College, Columbia University
525 West 120th Street
New York, NY 10027
212-678-3000

DESCRIPTION OF THE RESEARCH: You are invited to participate in a research study to share your story as a patient when you were recently in Lutheran Hospital. You can choose to join this study if you are from the Chinese culture, race, or ethnic background. You will be asked to share stories about your experience as a patient with the nurses who cared for you. The reason for this study will be to understand the meaning of nursing care from patients of different cultures. It is important to understand how a patient perceives the nursing care they receive so nurses can provide care that is meaningful for all people in our communities. The research will be conducted by a nurse who is a doctoral student at Teachers College, Columbia University.

Study Procedure: If you agree to be in this study, you will be asked to fill out a questionnaire and you will be interviewed. The interview will be audio-recorded to be sure it is accurate. The interview will take place in a quiet room in the hospital. You may choose not to answer a question on either the questionnaire or during the interview. After the interview, you will be sent a copy of the typed interview to review and make changes if necessary, so it truly reflects your perceptions of the experience. You may also be asked to give a second 60-minute interview that will be audio-recorded. After the second interview, you will again be sent a copy of the typed interview to review and make changes if necessary.

If you do not speak and understand English, an interpreter will be used. The interpreters are employed and trained by Lutheran Hospital. Interpreters must pass a fluency test prior to the training. The hospital's Cultural Initiatives Coordinator is responsible for the Medical Interpreter Orientation. The interpreters will give you verbal assurance that everything you say will be confidential.

BENEFITS OF THE STUDY: A benefit of this study is that it may increase nurses' understanding of what a patient believes about their care so nurses can provide nursing care that is relevant to a patient's culture, values, and beliefs. It is most important to know this from the perspective of the patient.

RISKS OF THE STUDY: You will not suffer physical or psychological harm by being in this study. The research has the same amount of risk patients will have when discussing their illness. It may be upsetting for you to talk about having been in the hospital.

PAYMENTS: At the end of each interview, you will receive \$25 for the time you gave to take part in the study.

DATA STORAGE TO PROTECT CONFIDENTIALITY: Your information, including consent forms, will be kept confidential and will be used only for professional purposes. It will be kept safe in a locked file drawer in the researcher's home. All information you provide on the questionnaire and during the recorded interview will be coded with a number assigned to your questionnaire and audio-taped interview. You will be called by your first two initials during the interview to protect your identity. After the interview, you have the right to review the recording. Recordings will be destroyed once it is put in a typed format. All information including questionnaires and typed interviews will be kept safe in a locked file drawer in the researcher's home. All questionnaires, typed interviews, and code information will be shredded after 5 years from completion of the study.

TIME INVOLVEMENT: Your participation will take approximately 1½ to 2½ hours in the following activities. (1) It should take 60 to 90 minutes to fill out the questionnaire and participate in the interview. (2) If you participate in a second interview it should take 60 minutes. (3) There will be additional time involved for you to review a copy of the typed interview.

HOW WILL RESULTS BE USED: The results of this study will be used to increase nurses' understanding of meaningful nursing care for people of different cultural backgrounds from the perspective of the patient. The results will be used for the researcher's dissertation and may also be used to present at conferences or published in journals.

Teachers College, Columbia University
 525 West 120th Street
 New York, NY 10027
 212-678-3000

PARTICIPANT'S RIGHTS

Principal Investigator:

Deborah Little

Research Title:

The Lived Experience of Nursing Care among Multicultural Patients in a Hospital
 Nationally Recognized as a Culturally Competent Healthcare Organization

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care.
- The researcher may withdraw me from the research at her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is **201-232-2509**.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact:

Teachers College, Columbia University Institutional Review Board / IRB.
 The phone number for the IRB is 212-678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.

NYU Lutheran Medical Center Institutional Review Board / IRB.
 The phone number for the hospital IRB is 347-377-4168.

- I should receive a copy of the Research Description and this Participant's Rights document.
- I () consent to be audio-taped.
 I () do NOT consent to be audio-taped.
 The written and audio-taped materials will be viewed only by the principal investigator and members of the research team.

- Written materials () may be viewed in an educational setting outside the research.
Written materials () may NOT be viewed in an educational setting outside the research.

Signature of Participant: _____

Date: _____

Printed Name of Participant: _____

Investigator's Verification of Explanation

I certify that I have carefully explained the purpose and nature of this research to _____ (participant's name) in age-appropriate language. He/She has had the opportunity to discuss it with me in detail. I have answered all his/her questions and he/she provided the affirmative agreement (i.e. assent) to participate in this research.

Signature of Investigator: _____

Date: _____

Appendix E
Demographic Data Form

Participant Number Code: _____

Date: _____

Age: _____

Gender: _____

Ethnic Background: _____

What language do you speak at home: _____

What date were you last admitted to the hospital: _____

How many days did you spend in the hospital (last admission): _____

How many times were you admitted to the hospital: _____

If you have been hospitalized more than once, list the shortest and longest length of time you spent as a patient: _____ to _____

What reason were you admitted to the hospital:

Appendix F

Demographic Data

Data Criteria	Participants									TOTAL
	Study Site #1						Study Site #2			
	Home			Hospital			Church			
	01	02	03	04	05	06	07	08	09	
Gender:										
Male		X			X	X	X	X		55% (5/9)
Female	X		X	X					X	44% (4/9)
Age	93	65	56	74	68	95	45	64	57	45 - 95
Language:										
Cantonese	X			X	X		X	X	X	66% (6/9)
Mandarin		X	X			X				33% (3/9)
Length of Hospital Stay										
4 Days						✓	XX			22% (2/9)
5-10 Days				✓	✓				XX	33% (3/9)
11-15 Days	X									11% (1/9)
16-20 Days										
20-25 Days		X	X							22% (2/9)
26-30 Days										
>30 Days								XX		11% (1/9)
Repeat Admissions	X			X	X	X		X	X	66% (6/9)
Length of Time interviewed after hospitalization	5 mo	5 wk	3 ½ wk				2 yrs	1 yr	3 yrs	

✓ = inpatient

XX = different hospitals

*mo = months

wk = weeks

yrs = years